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ABSTRACT

The study examines the status of behavioral management services for disabled persons in Alberta, Canada, and offers recommendations regarding alternative service delivery models for the Northwest Region of Alberta. Existing systems are addressed in terms of centralized service models, outreach service models, and combined residential and outreach models. Advantages and disadvantages of each type are noted. A literature review on development of a community behavior management service explores methods for assessment, consultation, and program evaluation. Data are then summarized on resources and needs from interviews with residential facilities, vocational rehabilitation centers, and school systems. Recommendations are then offered regarding provincial policy, the philosophical base, and goals and objectives of a comprehensive community behavior services system (CBSS) specific operating guidelines for a CBSS are listed. Appended materials include a bibliography and sample survey forms. (CL)

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Grande Prairie and District Association for the Mentally Handicapped

# RESEARCH AND DEVELOPMENT PROJECT
# BEHAVIOR MANAGEMENT SERVICES
# NORTHWEST ALBERTA

by

Western Industrial Research and Training Centre

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Final Report

August 30, 1985

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## Preface

This document represents the final report of a research and development project conducted by Western Industrial Research and Training Centre (WIRTC) for the Grande Prairie and District Association for the Mentally Handicapped. Appreciating an immediate need and apparent growing demand for additional behavior management services within the Northwest Region of Alberta, the Association commissioned WIRTC to undertake a study of regional needs and resources, and to further investigate selected service delivery systems in Canada and the United States that might serve as potential models for an expanded behavior management service within the region. Information from the various sources was then used as the foundation for the recommendations brought forward in this report.

Within Chapter I are details of the objectives and purpose of the study for behavior management services in the Northwest Region. Also described is the development of the study plan as well as the organization of the study.

Chapter II, Part A, provides brief sketches of alternative service delivery systems identified in North America, categorized within three primary models: centralized services, outreach services, and comprehensive (residential and outreach) services. The advantages and disadvantages of each major model are also outlined. Part B, sumarizes three topic areas relevant to service delivery. These include discussions on assessment approaches, consultation models, and program evaluation systems. The suitability of the various tests and methods reviewed is then briefly evaluated.

Chapter III contains the results of the data derived from the needs and resources assessment conducted in the Region. The results are presented according to the four major respondent groups: residential facilities, vocational training centres, school systems, and government service providers.

Chapter IV presents the proposed program components which were ultimately selected. The major recommended services comprise outreach behavior support, residential treatment/training for adults, itinerant day program worker, and a community advisory committee.

It is intended that this report will serve as a resource document. Its purpose is to provide the reader with a broad conceptual overview of the nature of behavior management services, as well as applied operational details that take a special focus on service delivery in rural areas. A review of various models by which service delivery can be achieved are combined with specific considerations of regional needs and resources. Together they form a developmental framework by which an actual funding proposal or other service delivery plan might be structured.

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### Acknowledgements

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MAXINE ADAM, B.A., was a Project Assistant in Grande Prairie who also worked for the Grande Prairie Council for Lifelong Learning.

BEVERELY WEST, former Research Secretary, typed several early drafts of this report.

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# Chapter I

# INTRODUCTION

## I. INTRODUCTION

> "... the development of more "normal" environments may be futile if the individuals in them do not acquire the skill/knowledge repertories needed to interact appropriately with that environment and the people in it." Morreau, 1985

The ideology of normalization, introduced nearly two decades ago by Nirje (1969), has had a profound effect upon the type and nature of services provided to persons who are mentally disabled. It was an idea that became a conceptual springboard; launching a massive campaign by consumer groups, advocates and professionals to decentralize the large institutional centres into systems of local community services.

These local services became the first generation of community-based programs where educational, vocational and residential services were physically integrated into the community. Many of Canada's mentally disabled citizens were "brought home", and for the first time, they had an opportunity to lead more normalized lifestyles. But the concept of normalization, and its advocates, demanded more than simply integration by virtue of physical proximity, and they had not forgotten those with more severe disabilities who still resided in Canada's remaining institutions.

The next stage in the evolution of services for the mentally disabled was to be in the provision of generic services (Lord, 1984); a second generation of community-based programs that offered integrated opportunities within regular community services. In addition, there was a move to integrate the more severely disabled into the community programs that had already been established. To achieve these objectives successfully, however, meant that substantive problems affecting community integration had to be addressed. The transition from institutional to community-based services to generic or integrated services was hampered by numerous political, social and

economic concerns that focus on several critical areas. Included in this list are a lack of community services or resources (e.g., trained personnel), community rejection of persons who are mentally retarded, and the lack of behavior management services (Scheerenberger, 1976). These are not new concerns, but rather, they are issues brought into sharper focus by efforts to achieve greater integration of all individuals who are mentally handicapped.

Moreover, these issues are critically intertwined. Small numbers of qualified staff who operate otherwise effective programs often lack the expertise, resources, and time to deal with aberrant behaviors in individuals who are mentally retarded. In turn, the presence of behavior problem individuals in the community can adversely influence community attitudes, as well as the willingness of those responsible for regular community services to support integration or mainstreaming policies. Those who had worked to establish day programs and community residential options were faced with the realization that successful integration of individuals with a developmental disability, especially those exhibiting problem behaviors, would need to learn how to live in the community. Otherwise, reinstitutionalization might become the unwelcome outcome.

The provision of effective behavior management services has therefore become one of the most crucial elements within any comprehensive service delivery plan because of the high incidence of problem behaviors among individuals who are mentally retarded, and because these services have an obvious significance in determining the likelihood of successful community integration (Eyman, Borthwick, & Miller, 1981). In several recent studies, problem behaviors have been identified as the antecedent to reinstitutionalization (Lakin, Hill, Hauber, Bruininks, & Heal, 1983) or failure in community placements (Pagel & Whitling, 1978).

In Canada the development of behavior management services is a relatively new phenomenon. It took a foothold in large urban centres

during the 1970s in response to community-oriented service delivery policies being brought forward, and to the deinstitutionalization programs that resulted. The rejoinder to behavioral services was usually an overwhelming demand as parents and professionals alike sought assistance in dealing with problem behaviors that interfered with the goals of social and personal independence. This demand has since grown as service systems move toward generic programs and the deinstitutionalization of those with more severe disabilities continues. The demand has also grown geographically into Canada's rural areas as community associations attempt to provide local services to their own residents.

Many of the behavior management services that were established in the larger urban centres were intended to serve rural service providers through outreach programs; a system often used to provide services in areas where the population base is too small or the support services too few to maintain independent rural programs. Outreach programs worked reasonably well, although response times to service requests were somewhat slower. But as deinstitutionalization programs progressed and local communities expanded their day program and residential options, the demand greatly overtaxed what the urban service was able to supply. In many regions of the country, including those in Alberta, lengthy waiting periods have become the rule rather than the exception.

Throughout much of Canada and the United States, the response to this growing need for behavior management services has been the development of proposals and program plans to expand existing services or to create new regional services more responsive to the expressed needs of rural community operators of day programs or residences, as well as parents. It is largely a grass roots initiative and it has emerged because of the experiences of those individuals with disabilities who desire to be independent and contributing members of society. For them and their advocates, behavior management services are a means of bridging the gap between the ideals of normalization and the practical realities of living within the community.

**A. Study Objectives**

The overall goal of this investigation was to develop a resource document that could be used to design or plan an expanded behavior management service for the Northwest Region of Alberta. Two major components of the Service to be considered were as follows:

1. a facility-based residential program in which mentally handicapped adults exhibiting severe behavior problems would receive intensive benavior management training for some short term period;

2. an outreach program providing either direct service to individuals with behavior problems in tne settings where the behaviors occur or consultation and support to parents and staff in the community to assist them in working with behavior problem individuals.

Furthermore, the study was to take a special focus in looking at ways to provide maximal services in all areas of the region, and thereby, to consider alternative strategies by which rural and remote areas can best be served.

A research plan to achieve the project goal was devised by addressing three basic oojectives. The first objective was to conduct a review and analysis of a representative sample of currently operating behavior management services, as well as any pertinent literature pertaining to the operation of such services. This data base would then be used to prepare an integrated and up-to-date prospectus of alternative service models that might be adapted for use in the Northwest Region of Alberta.

The second objective was to conduct a needs and resource assessment within the Northwest Region. Identification of actual or perceived needs compared to the resources currently available to meet those needs would show areas of service gaps, if any, and indicate the extent and type of additional services necessary to meet the demand.

Finally, information derived through the needs/resource assessment and the review of existant services would be integrated in the

form of a set of recommendations for use in the design of an expanded behavior management service.

### B. Study Plan and Data Sources

Objective 1. Review and Analysis of Existing Systems

Purpose:

- To review current models for operating behavior management services.
- To identify advantages and disadvantages of alternative service delivery models.
- To review current developments in assessment methods, consultation models, and evaluation procedures.

Procedures:

- Survey of selected organizations in Canada and the United States.
- Selected on-site visitations of behavior management services operating in Alberta.
- Computer search of information data banks and physical search of current periodical listings.

Data Sources:

Behavior management services operating in Canada were identified through direct contacts with provincial government information officers and social services resource directories. Agencies in the United States were identified through literature searches and through contacts with the Administration on Developmental Disabilities, U.S. Department of Health and Human Resources. Forty-five agencies identified from all sources were contacted by letter (Appendix A) requesting materials describing any outreach or residential programs they offered, including details about organizational structure, operating procedures and program content. Information gathered from fifteen respondents is presented in Chapter II: Review and Analysis of Existing Systems.

Also included in this section is a brief review of five Alberta agencies that provide varying degrees of service to developmentally or emotionally disabled individuals. On-site visits were made to Child

Development Centre, Edmonton; Community Behavior Services, Edmonton; Mapleridge Residential Treatment Centre, Edmonton; Behavior Support Team, Calgary; and 85th Street Residence, Calgary. The purpose of the visits was to directly review how the programs functioned and to develop an awareness of any unique features of these services from the perspective of experienced service providers.

Published information about behavior management services were accessed through physical and computer searches of several data bases made available through the University of Alberta. Data bases searched included:

1. Psychological Abstracts
2. Educational Resources Information Centre (ERIC)
3. Social Sciences Citation Index
4. Research in Vocational Education (RIVE)
5. Exceptional Child Index
6. National Index of Child Research (NICR)

Physical searches of card catologues, periodical listings, and microfilm indexes of several libraries were also conducted. Library holdings searched included those of the University of Alberta, Edmonton Public Library, Alberta Social Services and Community Health Library, Alberta Public Housing Library and the Alberta Public Works Library.

The data search revealed that most of the material written specifically about behavior management services is contained in unpublished manuscripts produced by individuals or organizations with interests in behavior management service delivery. An example of this type of report is a document entitled "Planning Behavior Management Services for Mentally Handicapped Adults" (1978) which was prepared for Alberta Housing and Public Works by Vischer Skaburskis, Planners, in cooperation with the Province of Alberta Advisory Committee on Adult Behavior Management (Appendix B). Most reports are also descriptive in nature, and within the limits of the present literature

search, there have been no formal evaluation studies comparing alternative models or approaches in the delivery of behavior management services. In the absence of empirical data to support the selection of one model or approach over another; a choice of service delivery system can, at best, be made on rationale grounds that suit the unique context of the region or area to be served and the political or social realities by which it is influenced.

There are but a handful of published works in the delivery of behavior management services although literature related to the topic, such as strategies for behavior change, form the content of numerous journals and books. For the purposes of the present study, information about behavior management service delivery models was integrated throughout the report but emphasized in Chapter II, Part A - Review and Analysis of Existing Systems. Part B of this chapter presents separate literature reviews in each of three areas identified a priori as important components of a behavior management service. Included are discussions of assessment procedures, consultation approaches, and service evaluation methods. Information sources for other areas of interest not discussed in detail are provided in the Bibliography section.

Objective 2. Needs and Resource Assessment

Purpose:

- To determine existing resources and current levels of service provision in the Northwest Region.
- To assess the perceived or actual needs of identified consumer groups.
- To determine the number of individuals with behavior problems and to profile client characteristics.
- To identify agencies for a potential liason or support role for the future development of an expanded behavior management service.

Procedures:

- Structured interviews with government personnel, organizations and associations throughout the Northwest Region.

- Review and integrate data from the needs identification study prepared by Behavior Management Services, Alberta Social Services and Community Health, Grande Prairie.

- Survey major consumer groups and resource personnel; vocational training centres, residences, school systems, and Alberta Social Service and Community Health Offices.

Data Sources:

The resource/needs assessment was accomplished through a series of survey questionnaires administered primarily during on-site visits with representatives of major agencies or organizations operating within the Northwest Region (as defined by the territorial boundaries shown on the Government of Alberta regional map - Appendix C). The threefold purpose of the survey questionnaires was to identify: (1) services currently provided and available resources; (2) the number of individuals presenting benavior problems, as well as the severity and nature of the problem behaviors, and (3) behavior management service needs, priorities for service, and extent to which the service is required, i.e., likely frequency of use. Survey questionnaires used with each respondent group are shown in Appendix D.

The primary respondent groups consisted of fifteen school systems or individual schools (e.g., Crystal Park School, Grande Prairie), five residential facility operators, seven vocational training centres, and six representatives from three service departments within Alberta Social Services and Community Health. The specific agencies who assisted in this project, and the individual respondents, are presented in Appendices E and F.

The final results of this survey work are presented in Chapter III - Needs and Resource Assessment.

Objective 3. Recommendations for the Design of a Prototypical Model

Purpose:

- To bring forward a set of recommendations regarding the future development or expansion of a behavior management service that

are based upon regional needs/resources and the review of existing systems.

- To present alternative organizational models and service delivery components that would meet the needs of the communities and that would be complementary to existing service delivery systems.

- To estimate the basic operational and capital requirements for undertaking a behavior management service.

Procedures:

- Integration of data derived from Objectives 1 and 2 of this investigation.

- Estimate costs on the basis of cost operating history of other agencies, area realtor reports, provincial government salary guidelines and other relevant information sources.

Data Overview:

Chapter IV, Recommendations for a Behavior Management Service in Northwest Alberta, provides a broad range of recommendations for the provision of regional behavior management services. The major service components includes outreach programs and a facility-based residential program for difficult to management clients. Both components were clearly identified as regional needs.

Specific recommendations are preceded by a brief statement of the underlying principles or concepts upon which service delivery goals and objectives are predicated. This statement is then followed by specific goals and objectives which, in the view of the authors, reflects the consensual views and expectations of the major consumer groups.

Recommendations contained in this report are intended to be open-ended since their actual implementation could conceivably take a number of equally effective formats. For example, a residential facility may be operated under a house parent model or a shiftwork model. While both approaches have their attendant advantages and disadvantages, their relative merits would depend upon a number of factors, such as the experience or preference of the operator. Thus, the actual blueprint for a service would be the mandate of the

proposed operator and other parties involved in the developmental process. An organizational model is also presented in this report as an exemplar and a basis of discussion.

The final section of this chapter presents a skeletal framework of the operational/capital costs required to operate a behavior management service in the configuration described in the recommendations.

## II. REVIEW AND ANALYSIS OF EXISTING SYSTEMS

### A. Service Delivery Models

In reviewing the literature on behavior management service systems and the materials requested from current behavior services in Canada, three service delivery models incorporating the fundamental issues of facility-style and service population presented themselves. These alternative models are outlined as follows:

1. A centralized, intensive residential or day program in which specially trained staff work with behavior problem clients for a specified time period within a specially designed setting.

2. An outreach model incorporating both direct service in which specially trained staff work with behavior problem clients for a specified time period within existing settings, and indirect service in which specially trained staff provide support, consultation, and backup to parents and staff in the community to help them work with behavior problem clients within existing settings.

3. Both a residential/day program and outreach program incorporating elements of both of the above models.

No two behavior management services are exactly alike. In order to meet the needs of their respective catchment areas, services must differ in regard to program emphasis, staffing arrangements, and organizational patterns. The specifics of different programs are largely determined by local needs and resources, as well as by subtle but significant influences arising from within each community's political process. For the administrator of a human services centre, such local variations must be matters of great concern. For the readers of this chapter a constant awareness that such differences exist is also of considerable importance.

Keeping in mind the distinctive characteristics found in each of the major models, it is possible to establish a typology of behavior service centers based upon common features of their organization. In the following chapter, a number of organizational categories within

each service delivery model are identified and described through examples of current programs in North America. In addition, the primary advantages and disadvantages of each model are listed. (Full addresses for each agency described are contained in Appendix F.)

## 1. Centralized Service Models

Centralized programs are those which operate within a particular location or facility to which clients must come to obtain services. Such services may be residential in nature, requiring clients to actually live at the facility for some period of time, or they may be day only, requiring clients to leave the facility at the end of each day. In some cases, both residential and day services may be offered separately within the same centralized program.

### a) Day Treatment Programs

The Rock Creek Foundation for Mental Health (Bethesda, Maryland) operates a day treatment program for 33 young adults who are both mentally retarded and emotionally disturbed. The clients engage in a 40-hour week of day activities that include behavior therapy, expressive therapy, and vocational rehabilitation. The Foundation's "normalizing" and community-based philosophy incorporates such features as clients working in various community job sites, an absence of mealtime programs to encourage clients to go to local restaurants or bring their own lunch, and the absence of separate lounges for staff and clients.

### b) Private, Non-Profit Agencies

The Ranch Ehrlo Society (Regina, Saskatchewan) is a private, non-profit organization for the purposes of providing care, education, and treatment for socially, psychologically, or behaviorally disturbed youth. The Society operates four types of programs:

- A residential treatment centre consisting of two living units located on the ranch near Pilot Butte.
- One special-needs unit on the ranch especially for emotionally disturbed youth or delinquent youth of lower ability.

- Four group homes and several independent living apartments within the City of Regina.
- Education and vocational programs geared to the special needs of residents unable to enter regular classroom settings.
- Other services available include social development, crafts and recreation programs.

The Mapleridge Residential Treatment Centre (Edmonton) is owned and operated by the Sisters of Our Lady of Charity. Four split-level cottages on a private campus within the city provide a home for ten children each placed according to their age and individual requirements. The Centre offers services for 30 emotionally and behaviorally disturbed children, ages 6 to 12, and for 10 adolescent girls, ages 13 to 15. The treatment program includes health care, education (either with separate or public schools, or an adaptation classroom contracted through Edmonton Separate School Board), group living, moral and spiritual practices, and recreation.

Forward House (London, Ontario), funded by Ontario Ministry of Community and Social Services, operates two residences and a day program for 13 adults who are mentally handicapped and who also exhibit aberrant behaviors. The organization was established in response to the closing of Start Centre (St. Thomas), an institution for the mentally handicapped, in order to provide behavioral treatment for problem residents that could not be accommodated by existing community services. One residence (opened in November, 1984) provides a relatively permanent home for six profoundly handicapped individuals, whereas the other residence (opened in March, 1985) accommodates six or seven higher functioning persons who will likely move to less structured homes eventually. A relief bed is provided for crisis intervention for use by other group homes in the area which may require temporary behavioral treatment for a particular resident. The day program offers work activity and skills training for the 13 residents of the organization. One aspect of the general service program is regular meetings with parents and significant others to involve them in the decision-making concerning the treatment programs.

Advantages

-A centralized program is less cumbersome to administrate and permits simplified coordination and integration of component services.

-A centralized program reduces the cost of professional travel, both in terms of hard dollar costs and time lost to client service.

-A central facility permits greater environmental control and, therefore, increases therapeutic consistency.

-A centralized facility permits varying degrees of security measures to be implemented, depending upon the needs of the clients.

-A centralized program is more easily monitored and evaluated.

Disadvantages

-A place is more likely than a service to set stringent criteria for admission, and to set limits on the number and type of individuals it can serve (Vischer, 1982).

-Large centralized programs are generally less flexible in regard to their ability to change with changing community needs.

-Parents, spouses, and friends of clients are less involved in the treatment program.

-Generalization and maintenance of treatment gains becomes problematic once clients leave the program.

## 2. Outreach Service Models

Outreach programs are those which offer clients services within their "home" environments. Such services may be direct to the individual demonstrating behavior problems or may involve support, consultation, or backup to parents and/or other professionals in the community to help them work with behavior problem individuals within their natural environment.

a) Private, Non-Profit Agencies

The Regional Intervention Program (RIP; Nashville, Tennessee) utilizes a three-tiered organizational approach to treat mentally retarded/mentally ill children. On the first level, all front-line service delivery functions are carried out by parents. They conduct intake conferences, and provide emotional support and technical advice for new parents. On the second level, six professional resource persons serve as an advisory and resource force. The third level is a seven-member evaluation committee of parents and community professionals— chosen by the parents— who monitor all treatment activities and report monthly to the Tennessee Department of Mental Health and Mental Retardation. RIP is administrated using a management-by-objectives system in which behavioral targets are time-bound, numerically delineated, and individually formulated. There are no fees; while the state pays the operating costs, the parents agree to a pay back plan (a minimum of nine hours per week for six months) of working for the organization.

The Outreach Program of the Delta Family Services Society (Delta, British Columbia) provides in-home, professional counselling services to families with children or adolescents presenting emotional or behavioral problems. The program is staffed by five Outreach Counsellors and a Clinical Psychologist. The treatment program begins with an initial assessment of each family's problems, their goals and expectations for change, and an in-depth exploration of the factors contributing to family difficulties. An intervention program is then established in which parents are taught methods of systematically promoting desirable behaviors and discouraging undesirable behaviors. A Family Therapy Program, usually reserved for families with adolescent children, teaches communication, conflict resolution, problem-solving, and cooperation among family members.

The Child Development Centre (Edmonton) is a private, non-profit clinic of the Alberta Child Development Foundation. It provides multidisciplinary services to children from birth to 18 years

of age with learning disabilities, emotional or behavioral problems, and developmental delays, and to adults charged with the care of these children (natural and foster parents, social workers, teachers, and child care workers). Services include intellectual, academic, emotional, and developmental assessments and therapies (behavior management and play therapy) for children with emotional or behavioral disorders, developing personal and social competence, consultation to children of separated or divorcing parents, and single parent training.

b) Government-Operated Agencies

The Battlefords Mental Health Centre (North Battleford, Saskatchewan) provides psychosocial and community counselling services to the northwest region of Saskatchewan. One component, a child and youth services program, is designed to assist individuals under the age of 18 and their families in coping with social, emotional, and behavioral problems. Such assistance might involve assessment and evaluation of the problems faced by the child/youth, various forms of individual and group therapy, consultation to parents and schools, and public education concerning the needs of children, youth, and their families. The Lawson Centre program provides diagnosis, assessment, and treatment to adults in need of emotional and social coping skills and who wish to establish more meaningful interpersonal and family relations. A couples counselling program provides assistance to couples in distress by improving their communication and problem-solving abilities.

The Behavior Management Services (Grande Prairie) operated by Alberta Social Services and Community Health (ASSCH), provides support and training to handicapped individuals exhibiting problem behaviors and those who work and live with them. The goal of the service is to develop more acceptable and appropriate behaviors in place of problematic ones. One Behavior Management Consultant is based in the Consultation Services Unit of Grande Prairie and one Behavioral Outreach Worker is based in the ASSCH District Office in Barrhead. The Services offered include:

- Consultation— treatment and program planning, counselling (individual, family, group) and follow-up

- Training— upon request, workshops and short courses on behavior management to service providers, teachers, parents, etc.

- Planning and Evaluation— program effectiveness, client/community needs

c) University Affiliated Outreach Programs

Project TELEPAC (Logan, Utah) is a telecommunications based system that provides instructional packages to parents of severely handicapped children in rural areas of Utah. The central component is the Homebound Handicapped Resource Centre (HHRC) located within the Exceptional Child Centre at Utah State University. It contains a parent resource library, a curriculum resource unit, a multimedia collection, and the telecommunications system (consisting primarily of telephones with intercom speakers). In addition, a local program monitor (LPM), who is a local educator, healthcare or social worker, coordinates the identification and screening of potential families, counsels families and children, and acts as a liaison with the HHRC.

The Behavior Support Team (Calgary) is affiliated with the Department of Educational Psychology at the University of Calgary. (It should be noted that this service is just one component of an agency called Behavior Support Services, Calgary. The agency is described in more detail in the next section.) Three full-time and one part-time behavior specialists provide:

- Clinical services including assessment, treatment and program planning, counselling, coordination of services, and follow-up.

- Educational services including academic training at the undergraduate and graduate levels as well as in-service training workshops for rehabilitation personnel and families in various areas of behavior management.

- Consultation services to agencies, families, and generic services regarding aspects of behavioral interventions in more general terms.

d) Private, Non-Profit Outreach Programs

Catholic Social Services (Edmonton) is currently soliciting funds from Alberta Social Services and Community Health for a Family-Based Treatment Program. The proposed program will offer treatment to emotionally disabled children and their parents or guardians within their own homes and schools. The program is designed to provide short-term, intensive treatment (up to six months) to a client group of 8-12 families at any given time. It would operate using a Social Worker, Family Care Workers, and a representative from the school (the School Social Worker) that the child is attending. The clients who will be identified for treatment in the proposed program will be children who are at risk of being removed from their family and placed into foster or residential care.

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Advantages

- Clients can be maintained in their everyday setting without the disruption of moving to a new setting temporarily.
- Family and friends can be more involved in the therapeutic process.
- Staff and parent expertise in behavior management develops throughout the service delivery system.
- Maintaining clients in their normal environment reduces the likelihood of them or their behavior being labelled "problem" (Vischer, 1982).
- Outreach programs are likely to be less costly than a residential care program.
- Outreach programs are capable of reaching more people at one time.

- A decentralized service may have more flexibility in terms of individual requirements.

- Generalization and maintenance of treatment gains are more likely when therapy occurs within the client's natural environment.

Disadvantages

- Individuals who cannot remain in their homes will not have a "community" alternative to institutionalization.

- Program consistency and quality control are more difficult to monitor in a decentralized system.

- The flexibility of an outreach service may cause the number of agencies and individuals seeking the staff's services to increase faster than the staff can respond to them.

- Providing special treatment to an individual in an environment where no others are receiving it risks attracting undue attention to the problem and disrupting the treatment program (Vischer, 1982).

- Professional travel time and costs are substantially higher.

3. Combined Residential And Outreach Models

a) Consortium Approaches

The Westside Community Mental Health Center (San Francisco) was developed by and offers coordinated programming for nine separate agencies. The Consortium participants include three general hospitals, a children's hospital, two family service agencies, a psychiatric clinic, an independent day care centre, and an independent suicide prevention centre. A centralized administrative unit was established to integrate and coordinate the total program, in addition to serving as a fiscal agent. Through the variety of facilities each participating agency provides, the program offers several inpatient and outpatient units, day programs, consultation and education services, a home treatment service, and specialized services for children.

b) A Program in a University Hospital

The Alvin Buckwold Centre (Saskatoon) operates as part of the Department of Pediatrics of the University Hospital at the University of Saskatchewan and serves the entire province. An extensive variety of services is provided for developmentally handicapped children that includes diagnostic assessment, diagnosis and treatment for certain inborn errors of metabolism (e.g., phenylketonuria), counselling and guidance regarding management of retarded children at home, behavior adjustment, working with parents, stimulation and structured play programs for infants and toddlers, intensive learning programs for preschool children, book and toy libraries, and consultations to voluntary and government agencies. Travelling clinics (an interdisciplinary team of staff members from the Centre), by invitation, work with community resource persons to bring assessment and counselling services in other communities throughout the province. A biochemistry laboratory conducts research into the prevention of mental retardation and provides facilities for diagnosis and treatment of inborn errors of metabolism associated with mental retardation. The senior staff members of the Centre are faculty members at the College of Medicine and offer a course in mental retardation to medical and health science students; lectures and seminars to doctors, nurses, and others working with the handicapped in the community; practicum placements or internships; and special summer projects that provide field experience for medical students.

c) Government Operated Agencies

The Community Behavior Services (Edmonton) serves mentally handicapped persons with behavioral or developmental problems. Operated by ASSCH, it provides training and consultation in behavior management techniques to parents and other caretakers, two residential units for a total of six children requiring intensive and structured learning programs, and an adult assessment unit for up to three adults requiring developmental and behavioral assessment, individual training, and residential care. Full-time staff consists of 39 persons

(psychologists, social workers, intake workers, child care workers) including a rural community outreach counsellor located in Edson, Alberta.

Behavior Support Services - Calgary provides coordinated programming by various government (ASSCH) agencies for mentally handicapped individuals with behavior/emotional problems. Applications for behavior services are received through the Client Services Coordination Team, which is responsible for interviewing, assessing, and screening individuals. The required information is then submitted to the Calgary Residential Program Committee, an interagency committee composed of the major service organizations for mentally handicapped persons. The committee recommends appropriate services for individuals and monitors their progress once placed in residences. Several Transitional Homes serve persons (16 years of age and over) with mild to moderate behavioral difficulties. One intensive program residence, 85th Street Residence, serves individuals (18 years of age and over) with court-appointed guardians, who have been terminated from existing programs because of severe behavior problems. Training in all homes focuses on the reduction of maladaptive behaviors through adaptive programs and the increase of appropriate behaviors through the acquisition of residential, community and leisure skills. Finally, the Behavior Support Team (see Outreach Models - University - Affiliated Programs) provides specialized treatment/program planning for behavior problem clients that is designed to help maintain the clients within their existing programs. The Team also provides training and education for families, caregivers, and other rehabilitation or special education personnel associated with the referred clients.

Surrey Place Centre (Metropolitan Toronto) is a multi-disciplinary facility providing clinical services, research, and teaching concerned with developmental disabilities. The clinical services provided include assessment and diagnosis of the person's handicap to determine the type of program/treatment services that may

be required; psychiatric and neurological evaluation and pharamco-therapy; infant stimulation; a behavior management residential and outreach program; education evaluation and program planning with teachers; family counselling and education; short-term, parent relief care facility; and a toy library. The Centre conducts biomedical research activities and provides genetic testing and counselling for clients and their families when the handicap may have been caused by hereditary factors. Research is also on-going concerning the biological, social, and behavioral aspects of mental retardation and techniques to improve the communication skills of developmentally handicapped people. A current research and demonstration project is designed to obtain information on the home environments and parenting styles of slow-learning adults, maintain the development of children who have developmentally handicapped parents, and to evaluate the effectiveness of behaviorally oriented training in teaching handicapped parents to maintain specific parenting skills. Finally, an Information and Volunteer Services program operates to train and coordinate volunteers working in the various programs of the centre and to educate the staff and community by use of special speakers, films, and tours of the Centre.

The Geneva Centre (Toronto) is a Children's Mental Health Centre funded by the Ontario Ministry of Community and Social Services, to provide services for individuals with autism or symptoms of autism, their families, schools, and communities throughout the province. The Centre operates a short-term residential assessment and treatment program for 20 children/youth. Home and school consultation services are provided for the purposes of developing and supporting parents and teachers as therapists. Parent education courses, given to families upon request, involve either procedures to change family behavior patterns or understanding language development. A Community Therapy program provides intensive therapeutic intervention with the child in order to teach the functional skills required to remain living at home or to take advantage of other generic services. Consultation throughout the province where there are local service

providers can involve assistance in planning program content or may be related to specific autistic individuals in the program caseload. Upon request, the Centre provides courses, lectures, seminars, and workshops for family workers, teachers, community groups, professionals, and students throughout Ontario.

d) Private, Non-profit Agencies

The William Roper Hull Home (Calgary) is an extensive and specialized treatment centre for emotionally disturbed children, ages 6-16. It is privately operated under the direction of an Executive Director and funded (90%) through ASSCH. For the 80 children in residence, there are seven cottages which range from intensive care to the relatively unstructured milieu of group living. The outreach program attends to the needs of 30 children and families through a team of community counsellors supervised by a professional therapist. An open area school situated on the residential campus accommodates 70 children (both residents and outreach clients) and is generally directed toward the remediation of learning deficits. Other clinical services available include an assessment and research team, a four-person family therapy department, occupational therapy, recreational therapy, a volunteer program involving 50 trained volunteers, and the services of a consulting psychiatrist.

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Advantages

- A residential/outreach program can offer a variety of programs and is more flexible for the special needs of individuals.
- This type of model assures continuity of care, especially in terms of follow-up.
- Both types of programs means that a large number of clients can be served.

Disadvantages

- A residential/outreach program will require a large number of staff, more facilities, and therefore, have higher operating costs.

- It may be difficult to coordinate or organize the various staff and their services to minimize service overlap, over-inclusion, or exclusion.

4. Conclusions

As is readily apparent from the preceding brief overview of existing service programs, there are a multitude of different approaches to the organization of a community behavior management service. In many respects, there are as many variations as there are individual programs. This variability comes about because local needs and available resources, financial considerations, and political processes uniquely shape the mandate and structure of any service program. Be that as it may, with respect to basic service delivery approach, all programs may be classified as either centralized or outreach, or a combination of the two.

Centralized programs have certain clear advantages over outreach programs as well as a number of clear disadvantages. On the positive side, centralized programs are often politically more expedient locally because of their dependency on a local facility that will require local goods and services as well as create local jobs. Centralized programs are also more easily administered and permit simplified integration and coordination of services. Similarly, centralized programs are more easily monitored and evaluated. Centralized programs, particularly when situated within larger communities, are more likely to attract and keep highly trained professional staff and see to their continued in-service training needs. Such programs also greatly reduce the time and money spent on professional travel— although this comes at the cost of increased

inconvenience to clients. Professionals in centralized programs generally have better access to equipment and materials that are too expensive to be purchased in quantity and made available in a large number of locations. A further advantage to centralized programs is the greater control such programs permit over the assessment/therapeutic environment and the greater security available for dealing with more severely disturbed individuals.

On the negative side, centralized programs involve increased inconvenience and expense to clients and their families who must sometimes travel great distances to the facility to obtain services. This becomes a particular problem in regions of relatively low-population density. Further, a facility is more likely than a service to set overly stringent criteria for admission and severely limit the number of persons admitted. Centralized programs also tend to reduce opportunities for the involvement of family and friends in client intervention programs. Two more serious disadvantages of centralized, facility-based programs are their high cost (particularly residential programs) and the fact that intervention outside the client's natural environment dramatically increases the probability of poor treatment generalization and maintenance. Finally, larger centralized programs have a tendency to be less responsive and flexible with regard to changing community needs.

Some of the disadvantages inherent within centralized, facility-based programs can be attenuated by having the program run through a community board of directors with a strong commitment to meeting community needs, even as these change. Facility-based programs must also develop policies that open their doors to the active involvement of clients' families and friends in both the facility and individual intervention programs.

As is the case for centralized programs, outreach programs come with their own distinct advantages and disadvantages. On the positive side, many clients can be maintained in their everyday settings

without the disruption of temporarily removing them to a new setting. This approach to service delivery makes it easier to involve family and friends in the intervention process and thereby enhances the probability of generalized treatment gains and maintenance. The effectiveness of intervention is also enhanced by the ability to assess the individual's behavior in the environment in which it normally occurs. The opportunity for greater involvement of family and other persons in the community in the intervention process leads to increasing "community" expertise in behavior management. This is particularly the case where consultation is provided to local behavior managers rather than direct service to the disturbed individual. Outreach programs are generally less costly than facility-based programs, are capable of reaching more people over a larger geographic area, and have more flexibility in terms of individual requirements.

On the negative side, outreach programs are more complex to administer, monitor, and evaluate. It is more difficult to coordinate and integrate the various services that may be offered in the program. Outreach programs often have more difficulty attracting and keeping highly trained professional staff because of the inconvenience of constant travel, the professional isolation engendered by working alone in small communities, and the difficulty of continuing professional education and upgrading. Professional burnout and turnover tends to be high in outreach programs. Staff in outreach programs also often have more difficulty in getting to know the communities to which they travel. This is particularly the case if the region each staff person covers is overly large. Lastly, a totally outreach program cannot offer some of the intensive interventions available at a larger facility and cannot service those severely disturbed individuals who cannot be maintained in the smaller community.

Some of the disadvantages of outreach programs may be resolved by not spreading staff too thinly and by providing frequent opportunities for staff to consult with each other. Staff support is a central

concern for a successful outreach program. Outreach program staff must also have good liaison with specialized facilities and resources that may be available outside the outreach program within the region.

Combination programs offer a mixture of centralized, facility-based services and outreach services. Combination programs are able to incorporate the positive aspects of both types of programs while minimizing their individual disadvantages. The centralized facility can offer intensive, short-term residential or day services to help more seriously behavior disordered individuals and their families, and specialist consultation services to field staff in the outreach service. The central facility can also serve as a means of coordinating in-service training and support activities for the outreach staff. The outreach component can offer service to the majority of behavior problem individuals and their families in their own home environments. The outreach service can also coordinate ongoing intervention programs for clients returning to their communities from the central facility. This should positively effect generalization and maintenance of treatment gains. Combination programs can offer the greatest variety of services with maximum flexibility.

While it has been the purpose of this chapter to identify and describe a number of organizational categories, it is impossible in such an overview to provide a sufficiently detailed picture of the full range of possibilities included within each category. In the development of a behavior management service it may be helpful to keep in mind these several approaches and their individual characteristics. It is more important, however, to keep in mind the nature of the community to be served, the problems it faces, and the resources it offers.

B. Literature Review

This section presents an overview of current research pertinent to the development of a community behavior management service. Three areas are briefly reviewed and analyzed— assessment methods, consultation methods, and program evaluation methods. Each of these three areas will be discussed in turn, focusing on purposes and types in each category, followed by conclusions and recommendations. A somewhat evaluative stance will be taken in order to assist the reader in selecting options for inclusion in future programs or program proposals.

The first of three subsections discusses the assessment of current intellectual functioning, adaptive behavior, and individual behavior repertoires within natural community environments; three areas of functioning that have particular relevance to program planning for mentally disabled persons. The limitations with respect to program planning that are inherent in the normative assessment of intellectual and adaptive behavior are pointed out and a case is made for the practical utility of criterion-referenced behavioral observation approaches to assessment. It is argued that behavioral assessment procedures and outcomes are more directly related to intervention procedures.

The second subsection presents four approaches to consultation; that is, the psychoeducational model, the behavioral model, the social-ecological model, and the developmental model. It is suggested that each model provides for differences in the process or method of change, the focus of change, and outcomes. The discussion of each consultation model focuses on these differences and the specific role each approach can play in service delivery.

The final subsection presents three general methods of program evaluation— benavioral objectives, systems analysis, and decision-making. It is pointed out that each of these three methods uses a

somewhat different data base and the adoption of any one approach is often determined by the purpose of the evaluation. The strengths and weaknesses of each approach are discussed, and practical considerations are outlined.

## 1. Assessment Methods

Formal assessment is an important aspect of the total evaluation of the individual with mental retardation who is seeking assistance from behavioral services. The assessment of mentally retarded individuals usually includes evaluation of current intellectual functioning, adaptive behavior relative to sociocultural standards, and observational assessment of the individual's behavior repertoire within natural community environments. Standardized assessment tests are commonly used for screening and classification purposes, to aid in the decision making process regarding appropriate placement, and to diagnose specific problems for inclusion in treatment plans. Standardized tests can also play an important role in outcome evaluation as before and after comparisons.

### a) Intellectual Assessment

The development of psychometric instruments that precisely quantify individual levels of intellectual functioning has intensified efforts to more fully describe and understand what constitutes intelligence and intelligent behavior. However, a universally acceptable definition of intelligence has continued to elude the philosopher, scientist, and educator. Intelligence has remained a rather ambiguous term that refers to an inferred construct that includes processes of intellection, their accumulated outcome as evidenced by the acquisition of a body of knowledge, a store of personal insights, acquired cognitive skills, and their everyday generalization and application to new situations. Indeed, intelligence remains easier to measure than to define (Morgenstern, 1983).

Standardized intelligence tests provide a set of predetermined conditions and demands that call for a diversity of cognitive, perceptual, and organizational skills. Competence in these skills is based on social and educational expectancies of "normal behavior" in life situations. Intelligence quotients (I.Q.) are compound measures derived from number values assigned to successes on tasks graded for difficulty and assumed to require complex intellectual processes. Essentially, the I.Q. numerically summarizes a pattern of intellectual functioning (Morgenstern, 1983).

Assessment of intellect has several uses, of which the primary one is categorization. Often, in order to access services and programs, whether they be for persons of above average or below average intelligence, one must first be tested to verify that entrance requirements are met. This is especially true in relation to education but may also apply to training programs and residential services. Other purposes such as identification, may be more institution than person oriented, as, for example, when school districts seek to initiate special programs on the basis of numbers of low or high functioning students. Despite some claims to the contrary (e.g., Sontag, Baker, and Nelson, 1958; Kirkendall and Ismail, 1970)), intellectual assessments have no useful role in the evaluation of personality characteristics.

In and of itself, the determination of I.Q. is not prescriptive, that is, it does not suggest appropriate treatment strategies for behavior problems which may or may not be related to low intellectual functioning. It can, however, add to an understanding of the individual's total level of functioning and indicate something about the way an individual will learn. For example, persons with moderate to severe retardation will generally require a concrete approach to learning, involving frequent repetition and gestural cues in addition to verbal directives.

Outside the realm of education, there seems to be less value in knowing an individual's precise (as measured by I.Q. tests) intellectual capacity unless qualification for services is dependent upon this knowledge. The administration and interpretation of any standardized intelligence test is a costly and time consuming project, requiring the expertise of a certified psychologist. Should such assessment be required, there are a number of standardized tests available for administration by a psychologist.

i. Stanford-Binet Intelligence Scale

This test is designed for use primarily with children up to 16 years of age. To determine I.Q., a comparison is made between the chronological age of the individual and the mental age as measured by the test.

ii. Wechsler Preschool and Primary Scale of Intelligence (WPPSI)

This test was published for use with children aged 4 to 6 1/2 years. Like the Stanford-Binet, it has been shown to be a valid and reliable instrument for use with mentally retarded children but the I.Q.s attained with each test are <u>not</u> interchangeable for an individual (Sattler, 1974).

iii. Wechsler Intelligence Scale for Children- Revised (WISC-R)

The WISC-R is applicable to children aged 6 to 16 years. Two types of functioning, verbal and performance, are distinguished in this test, although the two are combined in arriving at a measure of I.Q.

iv. Wechsler Intelligence Scale for Adults- Revised (WAIS-R)

This test is for use with persons over 16 years of age. The format is very similar to the WISC-R with more sophisticated content.

Although all of the above tests were designed to measure intelligence, each was normed on, and is recommended for use with, physically normal persons only. Sattler (1974) has indicated that vision, hearing and oral speech are necessary for most subtests of the Stanford-Binet. At the younger age levels, good arm and hand use are recommended. The same restrictions apply to the various Wechsler Scales.

In practical terms, this means that mentally retarded individuals who also have significant sensory or motor deficits may be discriminated against by the use of these tests, which will tend to underestimate intellectual ability levels in the presence of these additional disabilities.

A further problem encountered may be the interpretation of results obtained under nonstandard testing conditions, as in the presence of disruptive or other counterproductive behaviors on the part of the test-taker. Reliability and validity of findings are questionable when test conditions deviate substantially from the standardized format.

A variety of tests exist that are used as substitute or alternative measures for more conventional instruments. These are generally brief devices that can save time and provide individuals with physical handicaps or severe language problems with a response format to intelligence test items. For example, the Slosson Intelligence Test (Slosson, 1971) is a relatively short screening test used to estimate Stanford-Binet I.Q.s. The test includes many items that appear in the Stanford-Binet. However, it was designed merely to yield a score— a quantitative index of intellectual functioning, rather than both a quantitative and qualitative picture of intelligence as does the Stanford-Binet. Its use as a screening instrument may be helpful, but it is generally not recommended for use as the only or primary source for classification decisions on the basis of intelligence.

Other screening devices include the Full-Range Picture Vocabulary Test (Ammons & Ammons, 1962), the Peabody Picture Vocabulary Test-Revised (Dunn & Dunn, 1981) and the Test for Nonverbal Intelligence (Brown, Sherbenou & Dollar, 1982). In addition, Murray (1980) has described several instruments that are appropriate for use with the physically handicapped. Any of these may be utilized in conjunction with other forms of assessment but none is intended to provide a complete picture of intellectual capacity.

The limitations inherent in standardized measures of intellectual assessment dictate reduced usefulness in the design and implementation of behavior change programs in the context of community behavior services. Therefore, it is recommended that careful consideration of these limitations be made before deciding to include routine assessment of intelligence in a behavior services assessment package.

b) **Adaptive Behavior Assessment**

An important component in the American Association on Mental Deficiency (AAMD) classification of mental retardation (Grossman, 1977) is the concept of adaptive behavior, which emphasizes the domain of everyday behavior rather than thought processes. Adaptive behavior refers to "...the quality of everyday performance in coping with environmental demands" (Grossman, 1983, p.42). Put simply, adaptive behavior refers to what people do to take care of themselves and to relate to others in daily living rather than to the more abstract cognitive potential that is implied by current conceptualizations of "intelligence". The construct of measured intelligence originated from the need to make an objective assessment of the individual's potential for academic achievement and, therefore, intelligence measures focus on verbal and quantitative learning, generalization ability, abstract reasoning, and concept formation. In contrast, the adaptive behavior construct is a measure of "social competency" that places emphasis on the individual's current ability to cope with environmental demands, most of which are nonacademic in nature.

In general, those behaviors which define social competency include self-care skills; language/communication; locomotion; basic number, time and direction concepts; self-direction; including inititative and perseverance; and the ability to move freely and interact appropriately within the community (Blackhurst & Berdine, 1981; Singer, Close, Irvin, Gersten & Sailor, 1984).

Assessment of adaptive behavior provides a general understanding of the relationship between social requirements and the manner in which the individual chooses to deal with them. Knowledge of the process by which individuals utilize available resources to meet social and environmental demands forms an important, and perhaps the most revealing, type of evaluation information.

Before looking more closely at assessment of adaptive behavior, a distinction should be made between lack of adaptive behavior and the presence of behavior problems. Instruments like the AAMD Adaptive Behavior Scale assess both, yet provide a separate profile for each subset of behaviors (Blackhurst & Berdine, 1981). In general, those "adaptive behaviors" whose presence is problematic, including abusive or destructive behaviors, excessive profanity, and stereotypic behaviors, might be better described as "maladaptive". For purposes of this report, the two categories of behavior will be discussed separately, with maladaptive problems reviewed in the general category of behavior assessment.

There are many problems inherent in the assessment of social competency, not the least of which is the subjective interpretation of responses (Blacknurst & Berdine, 1981). Standardized measures of adaptive behavior may allow comparison of individual performance to age norms or levels of intellectual performance (Singer, et al, 1984), yet still provide only a general estimate of adaptive functioning. The physical and social environment in which the individual lives can greatly influence the judgement of "competence". Consider, for

example, the variable expectations for social interaction across socio-economic levels, or the differing environmental demands in a town of 5,000 versus a city of half a million people.

A further problem with adaptive behavior scales is that most have poor adult norms either because the range of "normal" responses has not been fully explored or because they were normed on an institutionalized population of adults. Also, adaptive behavior scales tend to evaluate "practical" or "mechanical" intelligence as is required in self care activities, while virtually ignoring "social" intelligence. Social intelligence is described as the ability to understand and deal with social and interpersonal objects and events. It includes such variables as role taking (the ability to take another person's view), social inference (the ability to comprehend what is happening in a social situation), and moral judgement (the ability to reflect upon the ethical aspects of interpersonal behavior), to name a few. These behaviors clearly are less amenable to a paper and pencil type of evaluation than to behavioral observation in naturally occurring situations.

This brings us to a final criticism of adapative behavior scales: most evaluations of adaptive functioning are based on third party reports of the behavior of evaluees, rather than on first hand observation. That there is room for bias and misrepresentation is obvious.

The difficulties in assessing adaptive behavior in no way lessen the need for, or importance of, such an assessment. The key lies in keeping the basis for comparison compatible with the social and environmental demands placed on the individual in his or her normal milieu.

Since 1961, when the concept of adaptive behavior was first introduced into the AAMD definition of mental retardation, over 300 scales that purport to measure some form of adaptive behavior have

been developed. No one instrument can assess all the behavior domains relevant to adaptive behavior because this behavior will tend to vary across environments, cultures and the course of maturation. Most of the test instruments have not been developed in a sufficiently systematic manner to permit clinical judgements or provide assessment information required for broad-based evaluation.

Of the broader, "nationally oriented" measures, the following are the most commonly used:

i. Vineland Adaptive Behavior Scales (VABS)

This is a 1984 updated version of the original Vineland Social Maturity Scale. Three versions exist, the first two gathering data through interviews with significant others, and the third through teacher interview. The scale is age related and defines adaptive behavior by typical performance, not ability.

ii. AAMD Adaptive Behavior Scale (ABS)

As with most other such scales, the ABS (Nihira, Foster, Shellhaas, & Leland, 1974) is administered to a well-informed third party and makes no use of direct observation. Two large behavior domains are tapped, one reflecting basic survival skills and habits, the other focusing on maladaptive behavior related to personality and behavioral disorders. The test has been criticized for the use of overly value-laden and subjective statements.

iii. Adaptive Behavior Inventory For Children (ABIC)

Assessing through the use of a structured parent interview, the ABIC measures adaptive behavior in self-maintenance and in five social systems: family, community, peer group, school, and earner/consumer. It is relatively new but reasonably well standardized and offers strong potential as an assessment device.

iv. Balthazar Scales of Adaptive Behavior (BSAB)

This instrument can be administered by teachers or aides through direct observation (Balthazar, 1973). It is recommended for providing objectives for the design and development of behavioral programs (Robinson, 1980)

v. Scales of Independent Behavior (SIB)

A new assessment device, the SIB (Bruininks, Woodcock, Weatherman, & Hill, 1984), like the ABIC, measures functional independence and social interactive skills in the home, school and community. Unlike some of the others, it has been normed on both handicapped and non-handicapped subjects from infancy through mature adult levels.

The concept of adaptive behavior was added to the definition of mental retardation as an attempt to turn back the clock to a time (before IQ tests) when general social incompetence rather than measured intelligence was the basis for viewing someone as mentally deficient. Adaptive behavior focuses on the real issues of mentally retarded persons developing skills in daily living that form the basic coping strategies necessary for the successful encountering of the natural and social demands of the environment.

Although some might rightly argue that lack of social competence is not the basis on which one seeks assistance from a community behavioral service, an adaptive behavior assessment may be important in pinpointing areas of incompetence which trigger the inappropriate behaviors for which referral is made. Effective behavior change strategies must be developed in the context of a clear understanding of antecedent, as well as consequent, conditions for the maladaptive behavior. Suppose, for example, that the "problem behavior" is recurring tantrums. If these are merely an attention getting mechanism, then frequency can be reduced by giving attention for non-tantrum behavior. If, however, the tantrums occur because other needs cannot be communicated adequately, then treatment should include

both tantrum reduction and development of more effective means of communication. In this manner, assessment outcomes dictate or direct treatment programs.

c) **Behavioral Assessment**

In the context of a community behavioral services, assessment of maladaptive or inappropriate behavior is essential because, presumably, the treatment of such problems is the raison d'etre of behavioral services. Although behavioral assessment per se is by no means limited to maladaptive behavior, for present purposes, discussion will focus primarily on the assessment of undesirable or problematic behaviors.

The list of such behaviors is virtually endless, but tends to include physical abuse directed at self, others or the environment; stereotypic or eccentric behaviors like rocking and thumbsucking; offensive vocal behavior as in excessive profanity or shouting; and a variety of antisocial behaviors including stealing, running away and sexually aberrant behavior. It is not unusual, particularly in severely and profoundly retarded persons, to encounter more than one type of maladaptive behavior in the same individual.

Behavioral assessment involves monitoring specific units of behavior from an ongoing behavior sequence at predetermined time periods. It differs from other types of assessment previously discussed in that there exist no standardized instruments which tell one what to observe. Moreover, unlike adaptive behavior scales which usually involve a third party report of levels of functioning, all data in a behavioral assessment are gathered through direct observation of the behavior of interest.

The basic parameters in behavioral observation data are the onset-time of the behavior, its frequency of occurrence, its duration, and the context in which the behavior may occur. These parameters form the basis of assessment strategies such as frequency recording, continuous recording, interval recording, interaction recording, and momentary time sampling (Rojahn and Schroeder, 1983).

Another aspect of observational assessment is the complexity of the coding system, i.e., the number of behaviors that are simultaneously monitored by one system. The simplest form of behavior coding is monitoring one target behavior at a time. The advantage of one dimensional observation is ease of recording. However, measures of a single response most likely give an incomplete picture.

Extending the number of behavioral events that are included in the observation generally means more clinical relevance and usefulness. Monitoring multiple response categories provides information on a variety of behaviors and their interactions that are likely to be affected by treatment. The selection of response categories will depend upon various factors and is based on the treatment goal or the expected changes.

Because behavioral assessment requires precise and accurate recording of data, observers must be trained, not only in recording methods, but in skillful observation techniques. Since approximately 25 to 30 observations are necessary to develop an adequate baseline for the behavior in question, data collection cannot usually be done in a single session. For this and other reasons, it may be expedient to bring individuals in to a centrally located facility, like a residence, for observation. One must be aware, however, that a change in environment alone may result in exacerbation or remission of the individual's problematic behavior. Despite the relative inconvenience, data collected in the natural environment will tend to be more accurate and representative of an individual's behavior.

Properly conducted, the behavioral assessment will suggest the relative severity of the problem and the most appropriate form of programming: residential, outreach, or individual consultation. A clear picture of the baseline strengths and weaknesses is more relevant to the design of practical programs. Is the maladaptive behavior to be eliminated, or merely decreased to some more acceptable level? If the problem behavior is eliminated, is an acceptable behavior taught to replace it? The answers to these and other questions determine the treatment plan.

d) Conclusion

The quality and worth of assessment are judged by the effectiveness of the interventions resulting from the assessment. Robinson (1980) has suggested several implications of focussing on an outcome criterion in assessment:

i. There is little to be gained from assessing areas where no interventions exist to bring about change.

ii. Data gathering should be related to treatment and to providing evidence of its effectiveness, not merely to making a diagnosis.

iii. In order to demonstrate intervention effectiveness, assessment must be an ongoing process.

In practical terms, this means that since treatment is individualized, so assessment should be. The use of standardized tests, unless specifically designed for a handicapped population, is not recommended. Instead, assessment should be based on observations, rating scales, checklists and other criterion referenced tests. These, ultimately, will provide the most useful means of assessing and planning individual programs.

## 2. Consultation Models

Approaches to the consultation/treatment of persons who are mentally handicapped generally reflect fundamental attitudes, beliefs, and values about this population. Accordingly, different approaches provide for differences in the process or method of change, the focus of the change, and the outcomes. The differing forms of treatment can be organized into several predominant models (Baldwin, 1985). It should be noted, however, that these models are not necessarily mutually exclusive. Although the basic frameworks vary, the models often overlap in treatment dimensions, and no one model offers an approach which will encompass all types of service delivery.

### a) Psychoeducational Model

The psychoeducational model is a therapeutic approach that views the therapist's role as teaching personal and interpersonal attitudes and skills which can be applied to solve psychological problems. Ideally, skills are taught which the individual can apply to solve present problems, and which will aid him and her in solving future problems.

General skills training programs emphasize counselling skills, communication skills, interpersonal skills, relationship skills, etc. Programs designed to teach more specific skills tend to be focused on specific populations. Examples include coping skills for deinstitutionalized patients (Gutride, Goldstein, & Hunter, 1973), and job search skills for the chronically unemployed (Hunt & Azrin, 1973). Other programs that seem to have a blend of general communication skills and more specific skills are represented in some family therapy approaches.

Use of the psychoeducational approach involves teaching a variety of skills by explicit instruction and feedback in graded practice sessions. Often, role-playing is employed with audio or video feedback as an additional teaching modality.

One advantage of the model is its applicability as a preventive strategy to anticipate and deal with potential problems in advance. Another advantage is the potential for wide applicability by a number of diverse groups, both professional and nonprofessional. Because adaptations of the model have often produced preprogrammed aids to learning skills, these can be used to teach, or be taught by, parents, teachers, clergymen, counsellors, mental health clients, and others.

This model has much to offer in meeting the need for parent and staff training so often expressed by service providers. The educational/experiential format is particularly useful for frontline workers whose skills are put to the test on a daily basis.

Because of the "educational" approach taken by this model, it tends not to deal with person-specific problems, but rather to involve techniques and approaches which can be adapted by individuals to their own situations and problems. As a staff inservice training program model, the primary focus might be one of broadening the scope of available interpersonal resources with which to approach agency clientele.

Service consumers may benefit from this approach when it is applied to the acquisition of new skills but the model is generally inappropriate for dealing with seriously maladaptive behaviors.

**b) Behavioral Model**

The application of behavioral treatment procedures represents the primary therapeutic model for teaching mentally retarded persons. Behavior modification refers to the application of learning principles to effect changes in human behavior. These principles specify the lawful relationships that are presumed to exist between behavior and the particular environment in which it occurs. When a behavior (or "operant") is emitted, it operates upon the environment to generate consequences that influence the future probability of the behavior recurring (Skinner, 1953). More specifcally, behaviors that are

followed by rewards are likely to recur, whereas those followed by aversive consequences are not likely to be repeated.

Examples of behavioral techniques include reinforcement and extinction procedures, shaping and prompting techniques, modelling, and punishment. Each focuses in a unique way on the systematic manipulation of behavioral consequences. As outlined in a previous discussion of behavioral assessment, application of this model requires precise and accurate assessment of the behavior in question, plus a thorough knowledge of behavior change techniques and their effective application. Indiscriminate or misinformed application of behavioral principles can exacerbate problem behavior rather than reduce its occurrence.

Although general education of individuals in the theory and application of behavioral change techniques can be accomplished through a psychoeducational model, the design and implementation of specific programs requires the direction of a behavior specialist.

Unlike the previous model, which takes a preventive, self-help approach that is educationally based, the behavioral model is very person specific and therapeutic in focus. It sees "the problem" as centering with the individual and seeks to alleviate the problem by changing the person and the ways in which they interact with the environment.

Behavior change programs are most easily controlled, and hence most effective in a closed, cooperative environment. Everyone who has contact with the person whose behavior is to be modified is cognizant of the personal behavior modification program and can contribute through the administration of rewards and control of environmental conditions. For the person living in the community, and whose problem behavior manifests itself across environments, the difficulty of consistency in the application of behavior modification techniques may be enough to sabotage the program. Cooperation among family members, teachers and vocational training staff is essential for success.

Despite some of the difficulties inherent in the application of the behavioral model, it remains the most popular model for therapeutic intervention in a wide range of behavior problems. Behavior modification programs have proven successful in controlling and eliminating self-stimulatory and stereotypic behaviors (e.g., body rocking, head weaving) as well as self-injurious behaviors (e.g., head banging).

**c) Social-Ecological Model**

Complex interrelationships and interdependencies between the individual and his or her environment are among the central issues in the social-ecological approach to behavior change. The interaction between person-behavior-habitat systems is analyzed in order to identify and assess variables such as the person's lifestyle, interpersonal relationships, and rhythms of routine activities.

The concept of normalization (e.g., Wolfensberger, 1972) closely represents a social-ecological approach to treatment. Normalization refers to the movement toward making available to mentally handicapped persons those patterns and conditions of everyday life which are as close to the norms of the mainstream of society as possible. The focus of treatment is to offer persons life conditions at least as good as that of average citizens, and as much as possible, to enhance or support their behaviors, appearances, experiences, status, and reputation.

With this model, there is a shift in emphasis which takes some of the onus for change away from the individual and places it upon the community. In doing so, it does not deny the necessity for the individual to conform to society's norms, but rather it demands that society takes a broader and more accepting view of individual differences.

The move toward group home living arrangements as an alternative to institutional living demonstrates this. Within the group home

atmosphere, individual residents are permitted the rights and freedoms of any individual, provided these do not infringe on the rights of others. Within the community at large, there is an expectation that group home residents will be accepted and treated fairly. Apparent differences in appearance or skill levels will ultimately be ignored in favor of the overall impression of disabled persons as worthy citizens. Achieving this level of acceptance is a slow process consisting of give and take on both sides, which results, finally, in changed attitudes and behaviors in both person and environment.

Another example of a social-ecological perspective on behavioral treatment is behavioral ecology (Willems, 1973), the application and extension of the principles and techniques of behavior modification. The behavioral ecologist, like the behavior modifier, is concerned with controlling specific variables. Beyond the behavior modifier, however, the ecological approach works to understand the antecedents of behavior that will ideally lead to increased predictability and success in intervention.

The social-ecological model is unique in its equal focus upon the individual and the environmental system in which he or she functions. The approach offers a broad perspective that emphasizes physical and social components, but is also very personal in its focus on the normal rhythms and routines of the individual's life pattern.

The balanced focus of this model makes it an important one for community behavioral services. It points out the absolute necessity of considering the behavior of the individual in the context of environment. This is important when serving clients while they remain in the community and also when dealing with residential service consumers who ultimately will be moving to a nontreatment environment. Family and community education and involvement will do much toward ensuring successful behavior change programs.

d) Developmental Model

The developmental model emphasizes that the physical, social, and emotional development of a person follows a developmental hierarchy (Haring and Bricker, 1976). That is, development of behaviors or skills moves from simple to more complex, and that the more complex behaviors are generally the result of coordinating or modifying simpler response forms. For example, eye-hand coordination is the result of coordination of the primary reactions of visual tracking and grasping (Piaget, 1963).

Developmental pinpoints or critical periods have been suggested that emphasize crucial learning experiences (Cohen, Gross, & Haring, 1976) and can be used to match the person's stage of learning with the focus of treatment/training. For the mentally handicapped, early intervention procedures are stressed on the assumptions that:

- simpler behaviors must be present in the repertoire to serve as important components for complex behaviors, such as cognitive or linguistic skills;
- the likelihood of a person developing inappropriate responses may be reduced; and
- the primary care-giver can be supported in the often overwhelming responsibility of providing for mentally handicapped persons (Haring & Bricker, 1976).

Precise instructional procedures (e.g., Sommerton & Meyers, 1976; Smith, Smith, & Edgar, 1976) are employed to aid the person in working on new skills. These procedures can be divided into five phases: acquiring, strengthening, maintaining, generalizing, and applying the new skill. The specific techniques within each phase can vary across practitioners or clients, but generally follow behavioral principles. For example, helping a child acquire a new skill can be facilitated by the use of shaping, imitation, and intermittent reinforcement.

One positive contribution of this model has been to suggest a rate of progression through the developmental sequence that is unique for each individual. As a result, the myths and lack of understanding

concerning the expectations made of mentally retarded persons have been progressively dispelled. Further, the model has promoted a recognition of the importance of rich and stimulating early learning environments.

This model is predicated on the belief that most behavior problems are a function of developmental inadequacies. That is, in the process of social-emotional development, certain crucial behaviors have not been learned, resulting in a behavior repertoire which lacks a sufficient range of skills to deal with the social-emotional demands placed on the individual.

The implementation of such a model, which focuses on prevention rather than treatment, involves early recognition of those at risk for developmental discontinuity, and a commitment to ongoing consultation and intermittent intervention. The role of the primary caregivers cannot be overemphasized in the process of assisting an individual to acquire the essential skills and utilize them appropriately. Therefore, the model must include support as well as education of the caregivers and a lengthy commitment to the client.

**e) Conclusion**

The preceding models of consultation have the most to offer in the realm of community behavioral services. The focus of each is somewhat different and requires different staffing, facilities and service delivery models. In order to meet the varied needs of the region, however, aspects of each model may need to be implemented. In terms of eradicating specific maladaptive behaviors, the Behavioral Model is likely the most efficient but it is not sufficient to meet all needs. It often fails to take adequate consideration of the social-environmental world of the client, a prime consideration in the Social-Ecological Model. If prevention of problems is the primary focus, then the Developmental Model has much to offer. The Psychoeducational Model, with its emphasis on teaching, overlaps all other models but has some unique offerings in terms of staff training and development, and in teaching proadaptive skills to replace those maladaptive behaviors toward which most treatment is focused.

However, regardless of the specific consultation model(s) endorsed by a community behavior management service, professional staff should also strive to understand and acknowledge the emotional make-up and attitudes of the client and his or her significant others. There must be a realization that, although clients may objectively display similar behaviors, there may be a different set of emotional circumstances driving each behavior. In other words, the practitioner must become sensitive to the fact that each client is a unique individual with a unique background for each behavior. With this sensitivity the behavior change therapist will require listening skills, an ability to gain rapport, and a discretionary sense of how to use counselling skills. But this does not imply that the practitioner should learn and utilize skills in a rote manner. Instead he or she should have a discernment for which is the "best fit" approach with each client. This discernment comes in the form of personal and professional maturity which is developed by rich interpersonal experience and perception of the social environment.

### 3. Program Evaluation Methods

Service programs can and do survive without any formal evaluation processes in place. But government and private-sector funding agencies, commununity boards, and citizens' groups are increasingly demanding clear evidence of program accountability in human services. They want proof that human services programs truly solve problems, are worth the effort and cost, and have completely beneficial outcomes. Such proof can only come through formal evaluation processes.

Evaluation is a set of procedures to appraise a program's merit and to provide information about program goals, activities, outcomes, impact, and costs (Fink and Kosecoff, 1978). In recent years, a large and diverse body of research literature has come to be published under the rubric of program evaluation. The focus of these studies has ranged from explicating details of small organizations and small-scale programs to assessing the activities of massive government bureaucracies and multi-million dollar service programs. Initially, much of the impetus for doing evaluation studies came from organizations which held social programs accountable for their performance. In these instances evaluation research was expected to provide data on "value for money" to respond to concerns about financial responsibility. However, although cost-benefit analyses remain important, evaluation research has become increasingly accepted as a useful input for planning and policy-making. More and more, program directors are being asked not only what service is provided, how and at what cost, but also how closely the program meets the needs of the service consumers and the community as a whole. Today, program evaluation is no longer focused solely on issues of "dollars and sense" but, rather, the scope of evaluation has broadened to include the total socio-political impact of the service under scrutiny (Hermalin and Morrell, 1981).

There are a number of different models or approaches to evaluation, and any one evaluation study or ongoing system may embody more than one approach. The adoption of a particular evaluation model is often determined by the purposes which the evaluation is expected

to serve. Generally, evaluation may be seen to have two basic purposes: to determine the effectiveness of a program, and to improve a program (Fink and Kosecoff, 1978). In an improvement context, evaluation information is used to modify and improve the program; in an effectiveness context, information is used to establish the program's quality and outcomes. In both cases the type of information sought or the point at which it is gathered are quite similar, but the uses to which the information is put differ. Often a single, comprehensive evaluation can be put to both uses.

The following section discusses three general methods of evaluation, each of which sheds light on a different issue in the evaluation content (e.g., evaluation for what? of what? for whom?). This material cannot serve as a complete text on research design. The types of evaluation presented here are used because they are helpful for understanding how major concerns about what should be evaluated shift with the focus of the evaluation design. Following the discussion of evaluation approaches, some practical considerations will be outlined, enumerating more precisely the kinds of information which may need to be gathered.

**a) Behavioral Objectives (Goal Attainment)**

The behavioral objectives approach to evaluation is probably the most familiar and most popular among evaluation methods. It begins by taking the goals or objectives of a program as stated. Evidence is then collected as to whether those goals have been achieved. The congruence between the stated goals and outcomes is the measure of program success.

One advantage of the objectives approach is its face validity. The claims of a social program must be outlined at some point, at least as a basis for public funding, and these provide the basis for holding programs accountable. Another advantage is the highly definable technology available for goal-oriented programs. The goals can be stated in behavioral terms, and steps to obtaining them

can be worked out in great detail. This has appeal to novices in program design, in the evaluation process, and later in the explanation of the outcomes of the evaluation to a wide range of individuals.

At an organizational level, the arguments which are posed against the behavioral objectives approach include, among others: 1) there is great difficulty in differentiating the "real" goals from those goal statements which represent political outcomes, provide justification for funding requests and mobilize support from among different constituencies (Rutman, 1977); 2) goals are forever changing, often by necessity in response to internal and environmental demands; and 3) the exclusive focus on goals means that side-effects are ignored in the evaluation (House, 1976).

All of the above mentioned arguments against the behavioral objectives approach raise valid issues and difficulties. However, these points do not necessarily lead to the conclusion that the identification of goals for the purpose of evaluation should be abandoned. Rather, the implication is that an exclusive focus on formally stated goals is by itself inadequate. The task of the evaluator, therefore, must also include identifying latent goals as well as anticipated effects. Furthermore, because identifying all possible outcomes may make evaluation unwieldy, a process of setting priorities is necessary to determine the most crucial questions for inclusion in the evaluation. These may not always be apparent, especially to an "outsider" like the evaluation consultant, and should, therefore, be arrived at through consultation with both service providers and consumers, whose views may differ substantially.

**b) Systems Analysis**

The systems analysis approach represents an analysis of "process", examining the nature of several goals and the processes by which they are achieved. Generally, a consensus on goals is assumed, and the problem is to relate variations in a few selected outcome measures to differences in programs or policies.

An important component of the process evaluation approach is its reliance on social science methodology and quantitative data, which enables cause and effect relationships between programs and outcomes to be established. Moreover, systematic evaluations produce valid and reliable evidence which can be replicated by other observers if the results are positive and avoided if the results are negative.

The use of scientific methodology seems to represent at once the best and the worst of the systems approach. The approach is appropriate when the outcome measures can be reasonably reduced to a few possibilities and simple cause and effect relationships. However, in reducing everything to a few indicators, the outcomes of complex social programs may be misrepresented. The approach is most often criticized for leading to scientism— the view that the only way to the truth is through certain methodologies. Under the rubric of this type of evaluation, one might investigate issues such as: What relationships exist among staff members? Are administrative procedures and structures adequate? What do staff members believe about their work, their organization, and the services they provide? What services are actually provided?

Because the focus of this evaluation approach is on the structure and activity of ongoing organizations, it often involves observation and data collection during the time that program staff are actually carrying our their daily work. It may also involve a reasonable amount of interviewing of program personnel or collecting information from administrative forms or files which staff are expected to complete. Apart from the time taken by staff from other duties to provide this information, a sense of uneasiness might result from the evaluators appearing to check on how well people are doing their work. Such appearances, whether correct or not, might well affect what evaluators find out (Windle & Neigher, 1978). Another difficulty, if existing records are used, is the problem of drawing inferences from low quality data or from archives which may not be flexible enough for maximum evaluation utility (Morrel, 1977).

Furthermore, the complexity of the view taken in a systems analysis dictates that, for many organizations, an external consultant is required or sought. While there are certain problems with collecting information that can be used as measures of how well a program operates, it is essential that the program evaluator has knowledge of how the program was developed and implemented. It would seem at least equally important to understand, for example, how an organization's treatment plan affects a client as it would be to understand the relative extent to which such an organization achieves specified goals. Unfortunately, this method often fails to address client effects from the client viewpoint because of a tendency to see the client only from the organizational viewpoint.

c) **Decision-Making**

The decision-making approach suggests that the evaluation be structured by the actual decision to be made, i.e., by delineating, obtaining, and providing useful information for judging decision alternatives. Such a viewpoint is reflected in a definition proposed by Alkin (Alkin, Daillack & White, 1979): evaluation is the process of ascertaining the decision areas of concern, selecting appropriate information, and collecting and analyzing information in order to report summary data useful to decision-makers in selecting among alternatives.

Any social program involves a diverse group of people who stand at varying distances from the direct delivery of service to clients, who contribute in the decision-making process of the program. For example, consider the differing needs of teachers and school board members for evaluation information. Teachers might be interested in information based on group dynamic theories of how classroom behavior of individual children can be changed. School board members may have a more direct interest in information based on sociological and economic models of what happens to schools under various combinations of funding or class size (Morrel, 1977).

A primary advantage of the decision-making approach is that it focuses the evaluation by employing the criterion of utility. The data are collected, and then selected for reporting in terms of what will be useful or relevant to the decision-makers.

The dilemma which arises with this approach is that the decision-maker, who is usually identified as the program administrator, is given too much preference. This may result in the evaluation potentially being unfair or even undemocratic. Certainly attempts should be made to identify the main concerns of decision-makers for possible inclusion in the research, but issues that may not be of immediate importance should not preclude the possibility of pursuing them in the evaluation.

Further problems may arise when the evaluator tries to define the specific set of decisions to be served. Decisions are not usually expressed in clear alternatives, and often may not emerge until after the evaluation is done (House, 1976). Also, the decisions may change shape dramatically over time. Decisions that determine the fate of a program may not often be those anticipated by the evaluator or decision maker.

**d) Evaluation Data**

i. Programs

Evaluations are often conducted to determine whether and to what extent the programs currently in place are effective and meeting certain standards of care. Generally, there are four levels of measurement in the determination of program effectiveness:

- Effort evaluation, involving the enumeration of personnel and facilities.

- Performance, involving the analysis of admissions, discharges, and placements in any given time period.

- Adequacy of performance, involving assessment of:
  - the number of individuals admitted to the program compared to the number from the target population who remain untreated;
  - and the number of individuals discharged to the community who are not referred back or to other agencies for re-occurrences of identified problems.
- Efficiency, perhaps employing principles of cost-benefit analysis.

ii. Staff

Formal and informal evaluation of the skills of the staff should form a critical part of any yearly service evaluation. There are three general levels of measurement involving personnel:

- Performance, involving work skills (practicum design, written exam), conscientiousness, staff/client relationships.
- Development, involving attendance at in-services, workshops, seminars, or conferences; working to change identified skill deficits.
- Job satisfaction, involving morale, working conditions, staff/management relations.

iii. Consumer Validation

To alert staff to program deficiencies, thereby allowing for improvement in the quality of service provided, clients, parents, and other agencies should be asked regularly and formally about their satisfaction with the program. The evaluation may involve assessment of program techniques and their success, and whether a recommendation of the program would be given to others.

e) Conclusion

In summary, the proposed methods of evaluation research place major emphasis on the type of procedures to collect data and also on the purposes those data are expected to serve. If the evaluation is to be thorough, it should in essence employ all three of the above evaluation methods. An evaluation should focus on program processes, and not merely on effects or outcomes. The questions posed in an evaluation study should not place restrictions on considering the consequences of a program which fall outside the formally stated goals. Similarly, the questions pursued by the evaluation research need not be constrained by the information needs of decision-makers.

## III. RESOURCE AND NEEDS ASSESSMENT

Thirty-one facilities/agencies in the Northwest Region of Alberta which have some or all mentally handicapped individuals as clients have been contacted. Interviews were conducted with administrative personnel at five residential facilities, seven vocational rehabilitation centres, fifteen school systems, and four ASSCH offices (Appendix E). The purpose of the contacts was first, to determine the type and extent of services currently being provided for mentally handicapped persons, and second, to assess the number of potential clients and perceived needs for behavioral services by clients and agency personnel. While the questionnaires (Appendix D) for each type of service organization varied slightly, the overall content of information sought was the same.

A description and summary of the data obtained in the interviews is given below. The information is presented according to service organization. Within each service organization section, questions pertaining to resources and to needs are grouped accordingly. The number headings below (e.g., (A-#1)) correspond to the section and question number, respectively, in the individual questionnaires.

### A. Survey Results

#### 1. Residential Facilities

**a) RESOURCES**

**(A-#1) What is the total number of spaces currently available?**

There are approximately 111 permanent and seven temporary beds in residential facilities for the mentally handicapped in the northwest region. The average residence provides six beds.

**(A-#4) Indicate services provided.**

The residential service agencies surveyed generally provide lifeskills training, interpersonal skills development, and recreation programs. Two agencies also offer vocational programming that incorporates work adjustment training and community-based job experience. Neither formal education nor counselling services are

provided by residence staff, but assistance is given as necessary on related issues such as problem-solving skills, homework, etc.

(A-#5) **Specify entrance and exit criteria.**

The entrance and exit criteria define the conditions under which a resident is accepted into and discharged from a residence. Two agencies require that the individual be at least 18, and all specify that the residents attend day or school programs or have regular employment. Residents may be required to leave the home if they stop attending the day programs or if they have reached a more independent functioning level.

(A-#6) **Do you expect to increase or decrease services in the next 3 years?**

Residential service agencies within Peace River and Grande Prairie have plans to increase the number of residential spaces by approximately 14 within the next two years. The remaining agencies generally expressed a need for more residential services for adults in light of the Michener Centre relocation program, and for children so they might move into the Grande Prairie area to enable them to attend Crystal Park School.

(D-#1) **Indicate the number of staff in each area.**

There is a variety of personnel that provides a wide range of expertise in the residential facilities. All of the agencies have one or more individuals working as the coordinator or supervisor. Among the support staff directly employed by the agencies are approximately 36 rehabilitation practitioners, 25 program workers, 2 social workers, and 2 vocational program workers.

(D-#2) **Describe your organizational and staffing model.**

All of the residential facilities surveyed are operated as private organizations headed by a board of directors. Supervisory staff can include a residential committee and residential coordinator (in cases where there is more than one home), and working within the

home, a residential supervisor. One or more program workers are available throughout the day and night in the homes on a full and/or part-time basis.

(D-#3) **Indicate the qualifications of staff.**

Of the staff members employed in residential facilities for the mentally handicapped, 35 have high school diplomas, 12 have rehabilitation practitioner diplomas completed and 5 are partially completed, 5 have a bachelor of arts degree, and 1 has partial credit towards a master of arts degree. The staff have an average of 5 years experience in the mental retardation/rehabilitation field. The average staff turnover period is 2.7 years (range = 1 to 5 years).

(D-#4,#7) **How many staff members have specific training in behavior change program design or other intervention strategies for behavior problems?**

Within the residential facilities, the majority of staff members have specific training in behavior change program planning, whether through university degree programs or workshops, in-services, seminars, etc. attended for specific purposes. Topics covered in recent workshops include behavior management, autism, vocational job placement strategies, learning styles, human sexuality, and drug and alcohol abuse.

(D-#5,#6) **Have you sought to hire, and are you able to hire staff who have expertise in behavior change programs or related skills?**

All respondents indicated that they sought to hire personnel with expertise in behavior change programming or related skills. However, each noted that it has often been difficult or impossible to hire such personnel due to issues such as relocating to a rural area and lower salary levels.

6) NEEDS

(B-#1) **Age Range**

Individuals currently living in the residential facilities surveyed range from age 7 to age 65. The average age of these individuals is 23.

(B-#1) **Indicate the primary disability and number of individuals in each of the following categories.**

The number of residents with a primary disability of mental handicap is currently 94: 24 mild, 59 moderate, 9 severe, and 2 profound. Seven residents were identified as having psychiatric illness as a primary disability, four residents have multiple handicaps, one has had brain trauma, and one is hearing impaired.

(B-#2) What is the average length of stay by clients?

The range of average time spent in the care of the residential service agencies surveyed is from two months to five years; the average duration of stay is approximately two years.

(C-#1) How many individuals have exhibited behavioral proolems in the past 12 months?

For purposes of this study, behavior disorders were classified into two major categories, with three levels of severity within each category. The behavioral classification scheme is as follows:

Internal Behavior Proolems - The behavior is primarily disruptive only to the individual.

Mild - Socially inappropriate behaviors often include self-stimulation, body-rocking, verbal repetitions, and pica, for example.

Moderate - Withdrawal or avoidance behaviors that often interfere with the training process.

Severe - Self-abusive behaviors often include forced laughter or crying, self-multilation (head-banging, voluntary falling, wrist-biting).

External Behavior Problems - The behavior is disruptive to other persons or other objects in the environment.

Mild - Disruptive behaviors often include obscene vocalizations, inappropriate expressions of affection, verbal aggression, and other manifestations of poor impulse control.

Moderate - Socially offensive behaviors, typically including lack of cooperation, emotionally reactive behaviors when provoked, minor theft or damage to property.

Severe - Aggression against others or against objects mostly takes the form of violent emotional outbursts, biting, hitting, kicking, or throwing objects.

The number of residents identified with behavior problems were as follows:

| | TYPE OF PROBLEM | |
|---|---|---|
| | Internal | External |
| Mild | 8 | 7 |
| Moderate | 22 | 10 |
| Severe | 8 | 6 |

(C-#2) **As far as you are aware, what percentage of behavior problems you experience are: confined to the facility; appear in other settings; originate in facility; originate elsewhere?**

The majority of identified behavior problems were not confined in their occurrences to the residence, but were known to

appear both inside and outside the agency's facilities. Indeed, four agencies indicated that 100% and one agency that 80% of the behavior problems were not limited to the home.

Two agencies responded that one half of the behavior problems tended to originate in the residences and the remaining half originated elsewhere. The remaining agencies indicated that most or all of the problems originated elsewhere.

(C-#3) **How do you currently resolve behavior problems at the residence?**

A pre-determined list of alternatives by which behavior problems are currently dealt with in the residence was to be rank-ordered by the respondents from the most likely course of action (1) to the least likely course, or last resort (5). These alternatives were termination from program, referral to other service but continues in program, seek consultation for staff to implement change program, design and implement program without outside assistance, and monitor situations.

The median rank orderings shown below represent the middle rank for the alternatives used in the residences. The median is defined as the 50th percentile, a score which is analagous to the "average" group preference. It should be noted that the same median rank can occur more than once when the median or"average" response is the same.

| | Disorder | | |
|---|---|---|---|
| | Mild | Moderate | Severe |
| Termination | 4 | 4 | 4 |
| Outside Referral | 3 | 3 | 3 |
| Staff Consultation | 2.5 | 1.5 | 2 |
| Design Own Program | 2 | 1 | 1 |
| Monitor Situation | 1 | 5 | 5 |

(C-#3) **Specify "Outside Refferal" and "Staff Consultation" sources.**

In instances where the residential service agency would refer a resident to another service or would contact another agency for assistance, several different sources were identified. All of the respondents indicated that they sought the consultation services of Behavior Management Services (BMS) either in Grande Prairie or Barrhead. Other agencies identified as providing assistance or for referring the resident to were Alberta Social Services and Community Health, Mental health Services and/or Client Services Coordinators, Community Benavior Services in Edmonton, medical/psycniatric professionals, Peace Counselling, and the Behavior Review Committee of the Grande Prairie and District Association for the Mentally Handicapped.

(C-#4) **Do you presently use the Behavior Management Services provided by ASSCH? What services do they provide you? How well are your needs met?**

Four of the five residential facilities surveyed indicated that they utilize Behavior Management Services. Such assistance generally involves treatment program planning, staff workshops and in-services, and information on behavior disorders. All respondents stated that these services were very well coordinated and helpful. However, it was unanimously emphasized that the services were not adequate in terms of accessibility, amount, and frequency. One residential facility indicated it had stopped making referals to BMS because the waiting list is much too long.

(C-#5) **What type of community behavior service, if any, would you utilize if it were availaole?**

The respondents rank-ordered a pre-determined list of services that might be provided by a community benavior management program. The most important service felt necessary was to be assigned the highest rank (1). It should be noted that when a service is ranked last on the list (7) it does not mean that it is unimportant. Rather, it means that the service was seen as less of a priority for the residential agency.

The list of potential services included assessment, client counselling, staff consultation (on-site teleconferencing), in-service training, information packages, and a short-term residential facility.

The median rank ordering is as follows:

| | |
|---|---|
| Staff Consultation (on-site) | 2 |
| Staff Consultation (teleconference) | 5 |
| In-service Training | 2 |
| Assessment | 3 |
| Client Counselling | 4 |
| Short-Term Residence | 6 |
| Information Packages | 7 |

(C-#6) **How frequently would you likely use these services in the course of 12 months?**

It was indicated that each of the suggested services would be used the following average number of times per year:

| | |
|---|---|
| Staff Consultation (on-site) | 26 |
| Staff Consultation (teleconference) | 26 |
| In-service Training | 2 |
| Assessment | 6 |
| Client Counselling | 52 |
| Short-Term Residence | 2 |
| Information Packages | 12 |

(C-#7) **Briefly describe the nature of content of the service you would like to have available for each of the following service categories.**

Staff Consultation: Comments regarding the specific content of consultation services to residence staff were: 1) assistance and information is needed in treatment planning for mentally handicapped adult populations in the region; 2) parents as well as staff need more support, training and information in dealing

with behavior problems; and 3) a regular review of the client caseloads with the staff and a behavior management specialist is needed in order that problems be recognized and dealt with as soon as possible and on an on-going basis. More generally, it was indicated that the consultation be readily available and frequent. It was also suggested that information about the consultation services be well advertised throughout the region.

In-service training: Suggestions for workshops, lectures, and seminar topics included management of various maladaptive behavior problems, basic psychology, abnormal psychology, and brain injury disorders and how to treat them. It was indicated that these services be available for parents as well as service providers.

Assessment: A comprehensive assessment program was suggested as necessary for purposes of understanding the basis of the handicap, placement decisions, and treatment planning. Several respondents emphasized that assessment is needed for adult populations in the region.

Client Counselling: Suggestions for counselling services included treatment for psychiatric and sexuality disorders. It was indicated that counselling is especially needed for children in the region.

Short-Term Residence: Respondents generally stated that the residence should have 3-4 beds and that residents be admitted for 3-4 months. One respondent suggested that the residence be used for assessment (3-4 weeks) as well as treatment.

Information Packages: It was indicated that information materials be readily available for staff, clients, and parents. The resources should contain information on how to treat various behavior disorders, general behavior modification and psychology readings,

current ways of treating behavior disorders in the home and the school by parents and teachers, respectively.

(C-#8) **Do you anticipate a growing need for behavior management services?**

All of the residential service facilities surveyed indicated they anticipated a growing need for behavior management services in the northwest region. This increase is closely tied to the Michener Centre relocation program. In addition, several facilities have plans to expand the number of beds which could potentially result in an increase in the need for behavior managment services. Other issues causing an anticipated increase in the need for services include an increase in aggressive behavior problems and in residents who have brain-injury disorders.

(E-#1) **How do you evaluate the effectiveness of your services?**

Three of the residential service facilities indicated that they provide a formal annual or biannual evaluation of their personnel. Staff are typically observed and measured for their performance in interacting with the residents, and the ability to design and implement programs. Strengths and weaknesses are noted and individual goals are established. Two of the residential facilities evaluate staff informally through conversations with staff, residents, other staff members, outside consumers, etc. Program evaluation is conducted formally in four of the residential service programs. This is done monthly, biannually, or annually and often presented to outside committees, boards, or ASSCH for approval. It can involve informal and formal observation of the resident, a checklist of skill performance, and/or goal attainment measures. Consumer validation is done formally in one residential program through conferences with parents and residents.

(E-#2) **Do yuu evaluate the effects of any active treatment programs on the client's behavior of performance outside of the residential setting?**

The effect of current treatment programs on behavior outside the residence is measured in one residential program. This is done through meetings with staff from the residence and vocational rehabilitation centre where many of the clients are working.

(E-#3) **Do you follow-up clients following discharge?**

Residents are followed up formally after discharge in three of the residential programs. One program contacts the resident monthly up to 12 months, one contacts the resident after 3 months, and one contacts the resident after 1 month. The remaining programs rely on Alberta Social Services and Community Health to maintain contact or it is done informally through meetings in the community.

(F-#1) **How is the residence funded?**

All of the residential service facilities receive funding from Alberta Social Services and Community Health. One residence also receives revenue on a per diem basis from the school system the children are attending. Other sources of revenue often include donations and fund-raising projects.

(F-#2) **Indicate approximate costs for staffing & operations.**

The salaries of front-line workers range from approximately $19,000 - $22,000. Supervisor/coordinator salaries range from approximately $22,000 - $28,000. The average total cost (including salaries) of operating a group home in the region is between $120,000 - $160,000.

(G-#1) **Describe your residential facility.**

Two of the residential agencies operate one home each, one agency four homes, one agency ten homes, and one agency a varying number of homes depending on the needs of the caseload.

The homes range in size from 1050-3000 square feet, with the average size approximately 2000 square feet. In the larger homes, the average number of rooms is about 14, with an average of five bedrooms for residents, and one bedroom for staff.

(G-#2) **Is your facility wheelchair accessible?**

There are approximately five homes in the region that are wheelchair accessible. At least two of these homes are fully accommodating to the physically handicapped with such things as wide hallways, handrails, and low sinks, counters, and windows.

(G-#5) **How do you maintain good public relations with the community during the developmental stages and currently?**

The respondents indicated that during the initial planning of creating a group home in the community several steps were taken to ensure acceptance. Community members were often asked to join the board of directors, public meetings were held to provide the community with information and to discuss issues, and questionnaires were sent out to measure attitudes and knowledge.

Good public relations are currently actively maintained in the communities with group homes by having residents work in the community, inviting neighbors into the homes, encouraging the community to volunteer to help in the recreation program, and presenting lectures and discussions to local committees and organizations.

(G-#6) **Do you have any other comments regarding concerns or needs for a community behavior management service?**

Two of the residential facility respondents indicated the importance of working with and providing support for parents of the clients. Other comments concerned the need for more staff in the behavior management service, the importance of coordinating the service with other services in the area, the importance of a prevention program and a board of directors that consisted of professionals as well as parents.

## 2. Vocational Rehabilitation Centres

### a) RESOURCES

**(A-#1) Indicate the number of spaces currently available in your programs.**

There are currently approximately 161 spaces in the vocational rehabilitation centres in the Northwest Region.

**(A-#1,#2) Indicate services provided and number of spaces for the current fiscal year.**

| | Smoky River | Swan Ind. | High Prairie | Fairview College | GrandeP Reg Col | Peace River | Blue Heron |
|---|---|---|---|---|---|---|---|
| Work Activity | | 15 | | | | | 15 |
| Work Adjustment | 10 | 48 | 8 | 15 | 10 | 10 | 20 |
| Rehabilitation | | | | | | 5 | |
| Job Placement | *** | | *** | *** | Partial | | |
| Prevoc. Training | *** | *** | *** | *** | *** | | |
| Skills Training | *** | *** | *** | *** | *** | *** | *** |
| Behavioral Unit | | | | | | | |
| Counselling | | | Partial | *** | *** | Parti. | |

*** indicates existing programs

**(A-#2) Specify entrance and exit criteria.**

All of the vocational facilities surveyed specify that the trainees be at least 16-18 years of age. Six of the seven centres require a minimum level of functioning in the trainees, identified by data such as I.Q. scores and/or work skills checklist.

**(A-#4) Do you expect to expand your services in the next three years?**

A significant increase in the number of spaces in the vocational rehabilitation facilities is expected over the next two years. The anticipated expansion includes the following: work

activity - 15; work adjustment - 12; rehabilitation - 15; and unassigned - 7. One vocational program indicated that it had recently changed its two year program into a one year program due to funding cut-backs.

(D-#1) **Please indicate the number of staff in each area.**

Working with individuals in the vocational rehabilitation facilities are approximately 10 staff whose duties can be described as training/program instructors, 3 manufacturing/production workers, and 13 training/production instructors.

(D-#2) **Please indicate staff qualifications (Training Staff only).**

The minimum level of education of the personnel is a high school diploma. Three centres have staff with rehabilitation practitioner diplomas, and three centres have staff with bachelor of arts degrees.

(D-#3,#4,#5) **How many staff members have specific training in behavior change program design or other intervention strategies for behavior problems?**

Four vocational facilities have at least one staff member with behavior management training. Three centres indicated that they have sought to hire staff with expertise in behavior change programming, and two centres indicated that they are able to hire such staff. Other respondents stated that they have been unable to hire or to retain staff with behavioral training due to the rural and relatively isolated location of the community.

b) **NEEDS**

(B-#1) **Age range.**

The age range of trainees in the rehabilitation centres is from 16 to 72 years; the average age is 23.

(B-#1) **Indicate the primary disability and number of individuals in each category.**

There are 138 individuals working in the vocational centres who can be classified as mentally disabled; mild - 43, moderate - 82, and severe - 13. There are four individuals who have been classified as having a psychiatric disorder as the primary disability, one whose visual impairment is the primary disability; and one individual identified as multiply handicapped.

(B-#2,#3) **Indicate the residential status of individuals, the distances travelled by clients from their residence to attend the program, and the number of individuals in each distance category.**

| Living Situation | No. | Distance to Work | No. |
|---|---|---|---|
| Independent | 23 | 1 - 10 km | 130 |
| Family | 32 | 11 - 20 km | 6 |
| Group Home | 64 | 21 - 30 km | |
| Approved Home | 13 | 31 - 40 km | 2 |
| Other - College | 14 | 41 - 50 km | 8 |
| Auxillary Hospital | 2 | 50+ km | 2 |

(C-#1) **Using the following categories, how many individuals have exhibited behavioral problems in the past 12 months? (See Residential Facilities section for behavioral definitions)**

| | Type of Problem | | |
|---|---|---|---|
| | Internal | External | Both |
| Mild | 10 | 15 | 1 |
| Moderate | 1 | 11 | 9 |
| Severe | 1 | 3 | 1 |

(C-#2) **As far as you are aware, what percentage of behavior problems you experience are: confined to facility; appear in other settings; originate in facility; originate elsewhere?**

The majority of identified behavior problems were identified as not being confined in their occurrence to the vocational rehabilitation centre. Five centres indicated virtually all of the behavior problems occurred in a variety of settings. Similarly, most

of the problems were identified as originating outside the centre. Two agencies indicated that approximately 50% of the behavior problems originated inside the centre and 50% originated elsewhere.

(C-#3) **How do you currently resolve behavior problems at the facility? Rank order from most likely alternative (1) to least likely alternative (5).**

| | DISORDER | | |
|---|---|---|---|
| | Mild | Moderate | Severe |
| Termination | 4.5 | 4 | 4 |
| Outside Referral | 4 | 3 | 3 |
| Staff Consultation | 2.5 | 2 | 2 |
| Design own program | 2 | 1 | 2 |
| Monitor Situation | 1 | 1 | 3 |

(C-#3) **Specify "Outside Referral" and "Staff Consultation" sources.**

In dealing with behavior problems in the vocational facilities, the respondents indicated that they would sometimes refer the trainee to another service agency or seek the assistance of other services in the region. Among the agencies identified were Alberta Social Services and Community Health, Mental Health Services, Consultation Services, Behavior Management Services, Community Behavior Services in Edmonton, the counselling department at Fairview College, the Behavior Review Committee of the Grande Prairie and District Association for the Mentally Handicapped, probation officers, school personnel, health unit staff, and social workers.

(C-#4) **Do you presently use the Behavioral Management Services provided by ASSCH? What services do they provide you? How well are your needs met?**

Four vocational rehabilitation centres indicated that staff members do seek the assistance of Behavioral Management Services. The types of services generally provided include consultation for staff in designing and implementing behavior change programs, information about various behavior problems, and in-services concerning relevant topics in behavior management. Respondents stated that these services were helpful, but that generally the services were not available often enough. Like responses from residential coordinators, the vocational centres' respondents indicated that the BMS caseloads were small and the waiting list too long.

(C-#5) **What type of community behavior services, if any, would you utilize if it were available? Rank order from the most important (1) to the least important (7).**

The median rank orderings were as follows:

| | |
|---|---|
| Staff Consultation (on-site) | 3 |
| Staff Consultation (teleconference) | 5 |
| In-service Training | 2 |
| Assessment | 3 |
| Client Counselling | 4 |
| Short-Term Residence | 7 |
| Information Packages | 6 |

(C-#6) **How frequently would you likely use these services in the course of 12 months?**

The average number of times the suggested behavioral management services might be used in 12 months was as follows:

| | |
|---|---|
| Staff Consultation (on-site) | 23 |
| Staff Consultation (teleconference) | 14 |
| In-service Training | 1 |
| Assessment | 12 |
| Client Counselling | 25 |
| Short-Term Residence | 1 |
| Information Packages | 16 |

(C-#7) **Briefly describe the nature or content of the service you would like to have available for each of the following service categories.**

Staff consultation (on-site): Suggestions for specific consultation services included assistance in identifying behavior problems, and in developing, implementing, monitoring, and evaluating behavior change programs.

Staff consultation (teleconferencing): Suggestions for teleconferencing consultation were the same as for on-site consultation in many cases. In addition, it was stated that teleconferencing might only be used for monitoring a program when frequent contacts are necessary. It was also thought that telecommunications might be helpful in providing support for staff and parents rather than being used in a consultative manner.

In-service Training: Topics suggested for in-services/ workshops in the region ranged from specific methods of controlling or changing a particular behavior to general psychology lectures. Job placement strategies, communication skills, contracting, administration/ management practices, and development of observation, recording, and implementing skills were among the many ideas thought appropriate for staff development.

Assessment: It was suggested that an assessment program involve the measurement of intelligence, vocational skills, physical health skills, behavior problems, emotional stability, psychological disorders, social behavior, and the home situation. The assessments could then be used for purposes of assigning the client to a particular residential and/or vocational placement and to provide a basis for designing remediation programs when necessary. It was emphasized by one respondent that assessments are needed for adults in the Northwest Region.

Client Counselling: Counselling services for clients were identified as necessary concerning personal hygiene, social skills, sexuality, problem-solving, accepting criticism, lifeskills, decision- making, and specific inappropriate behaviors.

Short-term Residence: Respondents suggested that the special residence have 3-6 beds, deal with violent behavior problems as well as non-violent ones, provide a day program for residents and others in the community, and provide a parent support service.

Information Packages: It was indicated that information would be helpful in conjunction with the in-services program and on the types of services/resources that are available from the behavior management service.

(C-#8) **Do you anticipate a growing need for behavior management services?**

Four respondents at the vocational centres identified an increasing need for services in the Northwest Region. This was suggested to result because of the Michener Centre relocation program, and because there are few existing services currently for adults and the severely disabled populations in the region.

(E-#1) **How do you evaluate the effectiveness of behavior change programs or any intervention strategy?**

Two of the vocational facilities in the survey indicated that personal observations are used to determine the effectiveness of any behavior change programs. Four facilities responded that they employ programs consisting of identifying and measuring program goals and skill or performance checklists.

(E-#2) **Do you have any other comments regarding concerns or needs for a community behavior management service?**

It was suggested that a community behavior service be readily accessible, provide frequent services and be used as a resource for information on behavior change programming. One respondent indicated that several trainee terminations and several reinstitutionalizations could have been prevented if more behavior services had been available. Several respondents noted that the long waiting list for assistance from BMS is clearly indicative of the need for more behavioral services in the region.

3. <u>School Systems</u>

a) **RESOURCES**

(B-#1) **Indicate the number of staff employed in educational programs for students with handicaps.**

In the school systems surveyed, the total number of staff employed in programs for mentally handicapped students is as follows:

| | |
|---|---|
| Elementary Teachers | 60.5 |
| Secondary Teachers | 25.0 |
| Elementary Teaching Aides | 70.5 |
| Secondary Teaching Aides | 9.0 |

| | |
|---|---|
| Vocational Teachers | 5.2 |
| Counsellors | 13.2 |
| Teacher/Counsellor | 9.25 |
| Psychologists | 2.0 |
| Therapists | 9.0 |

(B-#2) **How many staff members have specific training in behavior management?**

Staff with behavior management training 50.0 (24%)

(B-#3) **Do you offer special classes for persons with disabilities?**

Formal classes are held for students with disabilities in 10 of the 15 school systems in the survey. These classes vary in their material from teaching the learning disabled, the hearing or visually impaired, the trainable mentally handicapped, and autistic children. At least three of the school systems provide a resource room where children are taught in remedial programs as needed.

(B-#4) **Do you receive Educational Opportunity Funding (EOF)?**

Fourteen school systems indicated that they receive EOF. Two of those school systems reported that the funding is used specifically for classes for the mentally handicapped.

(B-#5) **Do you employ Individual Education Programming (IEP)?**

Fourteen of the school systems employ IEP that is designed according to Alberta Education stipulations. Such programs, primarily used with students who have special needs, can involve areas such as communication skills, mathematical skills, lifeskills, and behavior management.

(B-#6) **Do you attempt to hire staff with expertise in behavior change programs or related skills? If so, are you able to hire such staff?**

Eleven school systems reported that attempts have been made to hire staff with expertise in behavior change programs or related skills. However, only five of those school systems indicated that they have been able to hire such staff. Three school systems stated that they are finding an increase in the number of applicants

who have training in behavior change, while six school systems suggested that the inability to hire such staff is due to the rural region and salary cutbacks.

(B-#7) **Have your staff sought additional training in behavior management in the past 12 months?**

Staff members have attended workshops or seminars on behavior management and/or related topics in the past year in nine of the school systems surveyed. It was indicated that a total of 114 staff have attended approximately 50 training courses on topics such as autism, specific strategies for behavior change and how to design and implement change programs.

**D) NEEDS**

(A-#2) **Indicate the age range of students with disabilities.**

The ages of students with disabilities attending the schools in the Northwest Region is from 2-1/2 to 17 years of age in the elementary schools and from 12 to 19 years of age in the secondary schools. One school identified a 43-year-old attending secondary school.

(A-#2) **Indicate the primary disability and number of individuals in each category.**

The number of students identified with a primary disability of mental handicap was approximately 400: Mild - 230; Moderate - 121; Severe - 27; Profound - 11. The number of students with primary psychiatric disabilities is 7, with primary physical handicaps is 1, with primary visual impairments is 2, and with multiple dependent handicaps is 9.

(A-#3) **How many students have exhibited behavioral problems in the past 12 months?**

| | Internal | External | Both |
|---|---|---|---|
| Mild | 91 | 34 | 2 |
| Moderate | 18 | 27 | 19 |
| Severe | 4 | 9 | 5 |

(A-#4) **As far as you are aware, what percentage of behavior problems you experience are: confined to the school; appear in other settings; originate in the school; originate elsewhere?**

Eleven school system respondents indicated that they could identify approximate percentages concerning where the behavior problems originated and where they occurred. Eight indicated that 100% of the behavior problems occurred in the schools as well as elsewhere; the remaining schools responded that 50%, 20% and 30% of the problems were confined to the schools. Six school respondents stated that 100% of the problems originated outside of the schools, while five schools stated that between 75% and 90% originated in the schools.

(A-#5) **How do you currently resolve behavior problems in the school?**

The alternatives by which behavior problems are currently handled in the schools were to be rank-ordered from the most likely course of action (1) to the least likely course of action (8). The median rank orderings are shown below.

| | SEVERITY OF DISORDER | |
|---|---|---|
| | Mild/Moderate | Severe |
| Expelled | 7 | 7 |
| Suspension/Detention | 5 | 5 |
| Transfer | 6.5 | 8 |
| Outside Referral | 3 | 3 |
| Seek Consultation | 3 | 2.5 |
| Psychologist Referral | 2 | 2.5 |
| Design own Program | 2 | 2 |
| Monitor Situation | 2 | 2 |
| Other | N/A | N/A |

(A-#5) **Specify "Transfer", "Outside Referral", and "Staff Consultation" Sources.**

When the decision to transfer students with behavior problems is made, the places identified as often employed are the

Learning Assistance Centre (3), Community Benavior Services in Edmonton (1), Alberta Social Services and Community Health (3), and L.Y. Cairns School in Edmonton (3). Referrals to outside sources while the student continues in the school often include Crystal Park School (3), Behavior Management Services (4), psychiatrists/psychologists (2), Alberta Social Services and Community Health (6), AADAC (1), Indian Affairs (1), and Coordinated Assessment and Program Planning for Education (C.A.P.E.) (2). In seeking consultation for staff to deal with the behavior problems, the various services identified were Learning Assistance Centre (2), Alberta Social Services and Community Health (4), Behavior Management Services (1), Crystal Park School (1), psychologists/speech pathologists (1).

(A-#6) **Do you presently use the Behavior management Services provided by ASSCH? What services do they provide you? How well are your needs met?**

Nine school system respondents indicated that they employ the services of Behavior Management Services. The types of services it provides includes consultation for students and parents, program design assistance for teachers, and behavior modification information. Five of the school respondents stated that their needs were adequately to very well met, while six stated that the services were too overloaded to be of reliable service, not extensive enough provided limited follow-up services, lacked resources, and took too much time to respond to requests for assistance.

(A-#2) **What type of community behavior service, if any, would you utilise if it were available?**

The list of suggested services of a community behavior management program were rank-ordered by each respondent. The median rank-orderings are as follows:

| | |
|---|---|
| Staff Consultation (on-site) | 3 |
| Staff Consultation (teleconference) | 5 |
| In-service Training | 4 |

| | |
|---|---|
| Assessment | 1 |
| Client Counselling | 2.5 |
| Short-Term Residence | 6 |
| Information Packages | 6 |

(A-#8) **How frequently would you likely use these services in the course of 12 months?**

It was indicated that each of the suggested services would be used the following average number of times per year.

| | |
|---|---|
| Staff Consultation (on-site) | 19 |
| Staff Consultation (teleconference) | 9 |
| In-service Training | 4 |
| Assessment | 14 |
| Client Counselling | 15 |
| Short-Term Residence | 3 |
| Information Packages | 9 |

(A-#9) **Briefly describe the nature of content of the service you would like to have available for each of the following service categories.**

Staff consultation (on-site): The services requested for staff generally include assistance in designing behavior managment programs, providing recommendations and consultation to teachers and parents, participation in case conferences, and providing information and resources following assessment.

Staff consultation (teleconferencing): The telecommunications services suggested were very similar to those suggested for on-site consultation services. In addition, it was suggested that the teleconferencing services could be used in emergency situations and for general educational purposes in training teachers and parents.

In-service training: Respondents indicated that workshops be provided for parents, teachers, and teacher aides. The type of information thought necessary ranged from such general topics as behavior management strategy and assessment methodologies to specific topics such as treating a particular kind of behavior problem. It was also emphasized that this service could provide a needed liaison between school and home program maintenance by having workshops attended by both parents and teachers.

Assessment: Suggestions for assessment services involved tests for intellectual aptitude, emotional stability, social skills, educational levels, personality, and behavior problem identification. Once this information has been obtained, it was indicated that it could be used in assisting with program design, and given to parents to aid in treatment.

Counselling: Counselling services might involve direct services with the client and/or with the family and teachers. It was suggested that client therapy services are needed for many individuals to establish behavior change programs. It was also mentioned that family involvement is a very critical, but often absent, part of consultation. One respondent indicated that recommendations should be provided to the teachers for their assistance in program maintenance.

Short-term residence: Comments concerning a residential facility primarily centered around the minimum and maximum lengths of time a client should stay in the residence. The range of minimum times suggested for treatment was from one month to three months, and the range of maximum times was from one month to two years. Two respondents emphasized that the families be consistently involved in the treatment program.

Information Packages: Suggestions on content in the resource materials available through the behavior management service included how to treat abused and neglected children, emotionally disturbed children, behavior problem children; and information about the programs provided by the service and how they can be accessed. It was emphasized that the materials be concise and pertinent, as well as easily accessible and updated often.

(A-#11) **Do you anticipate a growing need for behavior management services?**

All but one school system respondent indicated that the schools might benefit from a community behavior management service.

It was generally reiterated that consultation services are needed for staff to design and implement programs in the classroom, that assessment of behavior problems be done by trained specialists as teachers often do not have the expertise or time to carry out the observation and testing, and that aspecial residence be provided to deal with severe behavior problems.

Six respondents stated that the number of students with behavior problems was increasing. It was suggested that this might be due to social pressures, poor economy, or a higher stressed society. It was also mentioned that parents of children with special needs are more often insisting that the child remain in the community rather than being transferred to other programs outside the region.

(B-#8) **Do you have any other comments regarding concerns or needs for a community behavior management service?**

Two respondents indicated that the need for staff training and upgrading in the area of behavior management would be extremely important in the school's continuing ability to deal with behavior problems. Another three respondents similarly emphasized having to deal with behavior problems in the schools in light of funding cutbacks by Alberta Social Services and Community Health and Alberta Education. Two respondents stated that the services for treating behavior problems in the region were satisfactory but that more services are needed and on an on-going basis.

**4. <u>Alberta Social Services & Community Health</u>**

**a) RESOURCES**

(B-#1) **Specify services for mentally handicapped persons with behavior problems.**

| | Slave Lake Child Dev. Coordinat. | High Prair Client Ser Coordinat. | Peace Rive Client Ser Coordinat. | Grande Pra Client Ser Coordinat. |
|---|---|---|---|---|
| Counselling | | Limited | Limited | Limited |
| Family Counselling | X | | | |
| Day Program | X | | | |
| Information/Referral | X | X | X | X |
| Workshops | X | X | X | |
| Home Visits | X | | ContractBas | |
| Consultation | X | | | |
| Assessment | X | | | |

(C-#1) **Indicate the number of staff employed in behavior change programs for clients with handicaps.**

All of the personnel working in behavior change programs at the Social Services units surveyed are social workers by university degree, totalling 6 staff altogether.

**b) NEEDS**

(A-#2) **Age range of clients with mental handicaps.**

The age range of the clients of the units surveyed is from 1 month of age to approximately 67 years of age. The average age of the clients is 25 years.

(A-#2) **Indicate the primary disability and number of individuals in each category.**

The number of clients with a primary disability of mental handicap is currently approximately 291: Mild - 117; Moderate - 152; and Severe - 22. There are 12 individuals who can be identified as multiply handicapped.

(A-#3) **How many clients have exhibited behavior problems in the past 12 months?**

The number of clients with behavior problems are as follows:

| | Type of Problem | | |
|---|---|---|---|
| | Internal | External | Both |
| Mild | 16 | 19 | |
| Moderate | 10 | 14 | 3 |
| Severe | 5 | 7 | |

(A-#4) **As far as you are aware, what percentage of behavior problems you experience are: confined to the school; confined to the home; confined to the workplace; appear in all settings?**

Three respondents indicated that the behavior problems they encountered were not limited to occurrences in any one environment, but appeared in all settings. One respondent identified 5% of the behavior problems confined to the schools and 5% confined to the home, and 90% appeared in all settings.

(A-#5) **How do you currently resolve behavior problems?**

The respondents were asked to rank-order suggested alternatives in currently dealing with behavior problems. The most likely course of action was to be assigned the rank of 1. The median rank orderings for each alternative is shown below.

| | DISORDER | |
|---|---|---|
| | Mild/Moderate | Severe |
| Referral | 2 | 1 |
| Seek Consultation | 3 | 2 |
| Design Own Program | 2 | N/A |
| Monitor Situation | 1 | 1 |

(A-#5) **Specify "Referral" and "Seek Consultation" sources.**

Behavior Management Services was identified as a service that clients with behavior problems would be referred to by three of respondents. The remaining unit identified ASSCH - Mental Health Clinic as a referral service.

(A-#6) **Do you presently use the Behavior Management Services provided by ASSCH? What services do they provide you? How well are your needs met?**

All respondents indicated that they presently employ the services of Behavior Management Services. The types of services usually requested include assessment of behavior problems, designing behavior management programs to be implemented by staff or family members with the client, and consultation and information. It was stated, however, that these services are not readily available. Concerns were expressed regarding the long waiting list (2 - 3 years)

to receive assistance, more support needed for families, more consistent follow-up services, the service being used more for severe problems while the mild and moderate cases are not helped, the service being available only to mentally handicapped clients and their caretakers while non-handicapped individuals must seek treatment elsewhere, and the lack of more outreach workers for the region.

(A-#7) **What type of community behavior services, if any, would you utilize if it were available?**

The median rank orderings are as follows:

| | |
|---|---|
| Staff Consultation (on-site) | 2 |
| Staff Consultation (teleconference) | 5.5 |
| In-Service Training | 3 |
| Assessment | 1 |
| Client Counselling | 5.5 |
| Short-Term Residence | 2 |
| Information Packages | 4 |

(A-#9) **Briefly describe the nature or content of the service you would like to have available for each service category.**

Staff consultation (on-site): Suggestions for consultation services were primarily concerned with the general program. For example, it was stated that the service provide assistance in "brain-storming" sessions with staff on particular behavioral problems; to provide professional feedback to staff on ideas for treatment programs; to offer home treatment programs implemented by the family; to provide expertise in working with native families and with brain-damaged individuals; and to teach skills in observation and program design.

Staff Consultation (Teleconferencing): Comments concerning telecommunication services were essentially a repetition of those for on-site services. In addition, it was suggested that a neuropsychologist and/or behavior management specialist be available on a regular basis for consultation through teleconferencing.

In-Service Training: Suggestions for topics of workshops, in-services, or seminars included intensive behavior

management techniques, training staff to train family members to deal with children with behavioral problems, ways to treat aggression, communication skills for staff and clients, interpersonal skills, and needs identification.

Short-term Residence: It was suggested that the residence be available especially for clients who are not placeable in group homes because of behavior problems. The respondents also indicated that treatment involve a maximum of 3 months, or up to 6 months as needed. Adults, rather than children, should be treated in the residence was the suggestion of one respondent.

Information Packages: The types of resource materials that were suggested included course work-books and related information for the workshops that the service provides, self-teaching techniques related to particular behavior management disorders, and a list of all the local agencies and their services. It was indicated that information and self-teaching programs would be valuable for family members. Also, information sources, if not readily available, could be listed via a computer software program as to where a particular resource document might be found.

(C-#5) **Do you have any other comments regarding concerns and needs for a community behavior management service?**

The respondents were unanimous in emphasizing that more behavior management workers and services are needed in the region. One suggestion was for a locked unit in the area (not an institution) to handle individuals with aggression problems. Another suggestion was to train several people in teaching lifeskills to families so that they in turn could teach their mentally handicapped children. Finally, it was stated that more follow-up services once the client has left treatment are needed.

## 5. Summary of Behavior Management Services Survey

Alberta Social Services and Community Health, Behavior Management Services has completed a needs identification survey for behavioral services in the Northwest Region (Appendix G). While the form of the questions was open-ended, many requested the same type of information that was requested in the specific questions of the present (WIRTC) survey. Comparisons of the responses from the two questionnaires indicated a number of complementary results, with virtually no conflicting information.

First, the present survey supports the finding of BMS that there is an immediate and increasing need for behavioral services in the region. It was generally agreed by both sets of respondents that this has been due to, for example, the opening of Crystal Park School in Grande Prairie, the trend by parents to keep children in the community, the Michener Centre depopulation program, and the lack of resources to house and treat an increasing number of aggressive individuals.

Second, both surveys endorsed that there are not enough staff working with mentally handicapped persons who are trained to deal with behavioral and/or emotional problems. The majority of respondents emphasized a need for in-service training, workshops, and seminars for staff concerning different behavior management strategies.

Third, corresponding needs were also expressed for more outreach workers and more extensive services dispersed throughout the region. It was felt that increased ongoing client consultation and follow-up, increased family support, and increased assistance to service providers in program design were among the critical but lacking services.

Fourth, it was similarly agreed that the lack of resources in the region has too often required that clients be transferred to services in other regions. Moreover, these outside services are very

limited in the number of spaces available, thereby causing a one to three year waiting period for out-of-region clients.

Fifth, most agencies in both surveys stated a definite need for an intensive treatment residential facility in the region. There are no residential resources to treat those attending Crystal Park School who may need twenty-four hour structured treatment programs, or those with violent behaviors in danger of being placed in Michener Centre.

A major issue addressed by the BMS survey concerned who should provide the behavioral services. The options that respondents were asked to comment on included an existing community service provider, the provincial government, and a community-based service which only offers behavioral services.

Summarizing the responses on this issue, the majority of advantages concerned the greater community orientation, familiarity, and accessibility that an existing or new community-based service would have over a government-run service. On the other hand, a service operated by the government was perceived as having a larger amount of financial resources that might allow more qualified staff to be hired, a generally higher standard of service to be maintained, and a service better able to deal with regional needs.

The disadvantages of either type of service also concerned community orientation. A government-run service was seen as insufficiently enough in touch with local concerns, while the community-based services were viewed as too locally focused, perhaps overburdening existing community resources (e.g., available qualified personnel, board membership, volunteers).

B. Summary Analysis

The preceding survey was conducted in the Northwest Region of Alberta to determine the needs and resources of four distinct types of agencies which serve persons who have mental handicaps. These included residential facilities, vocational training centres, school systems and social services agencies. The majority of the persons served were either mildly or moderately mentally handicapped and a substantial proportion of these clients were said to exhibit some form of behavior problem which is disruptive to their own training programs and/or to the peace and safety of others.

It was agreed among types of agencies that, at the present time, existing behavior management services within the community are taxed to the limit, resulting in long delays and infrequent contact when service is requested. Although most residential facility staff have some training in behavior modification, the majority of staff in vocational centres and schools have little or no formal training in behavior management. They are generally ill-equipped to deal with severe and complex behavior problems.

The most urgent needs identified for the region are for frequent and readily available staff consultation for behavior management problems and client/family counselling. There was also an expressed need for a facility capable of dealing with the most severe behavior problems in an intensive and highly structured atmosphere. The Michener Centre relocation program, an increase in aggressive behavior problems and increased numbers of persons with brain injuries were cited as evidence for needed increases in services and facilities. Along with the need for more facilities, there would be a concomittant increase in the need for trained staff. Difficulties already exist in attracting such people to the region because of the perceived undesirability of locating in an essentially rural area. If the needs of the region for assistance with assessment and program planning in the schools, residences and community agencies are to be adequately met, a concerted effort will be required to attract trained staff who will

provide education and consultation to parents, teachers, vocational rehabilitation personnel, and residental staff.

Recommendations for satisfying these and other conerns are discussed in greater detail in the following chapter.

**C. Michener Center - Residential Replacement Program (RRP)**

A letter was sent to the Director of Social Services at Michener Centre requesting information about the number of individuals who might be relocated to the northwest region, what type of behavioral support services they might require, and when the relocation program might begin. It was determined that approximately 16 residents could potentially move back into the region's communities. These individuals would need at least some form of residential facility and it was emphasized that good day programs be available for them. It was also expressed that access to behavior specialists would definitely be helpful. The RRP is contingent upon the availability of appropriate services for the residents in each community. It is planned that such services will be developed and provided by the provincial government and/or local agencies and associations within three to five years, although some speculation suggests that it will be the latter groups who will accept the major responsbility for initiating these services.

## IV RECOMMENDATIONS

### A. Provincial Policy

The planning of behavioral services in Northwest Alberta proceeds from the following provincial government policy objectives. These objectives have been identified by provincial authorities as minimum requirements or decision criteria (Short, 1977):

1. System and facilities to be developed in accordance with the philosophy and principles of normalization.
2. System and facilities to accommodate all ranges of behaviors and functioning levels.
3. Facilities to be accessible to the physically handicapped.
4. System and facilities to have diagnostic and assessment capabilities.
5. System and facilities to provide a multiplicity of treatment/training approaches.
6. System and facilities to be community based.
7. Services delivery and programs to be monitored and reviewed by a community board.

Two additional provincial policy issues exist that bear considerable importance in the current provision of social services within the province, as well as in the establishment of new services:

1. De-institutionalization— this refers to the release (i.e., phase-out or reduction in numbers) of mentally handicapped individuals residing in provincial institutions
2. Regionalization— this refers to the delivery of services within an individual's home region.

### B. Philosophical Base

The principles of normalization (Wolfensberger, 1972) form the philosophical base upon which the recommendations for a behavioral services system have been built. These principles dictate that services should use culturally valued ways and means to give handicapped persons culturally valued appearance, image, skills, and personal behavior.

This means that mentally handicapped persons should be provided with normal daily rhythms and routines which are as close as possible to the norms and patterns of the mainstream of society. Where it is deemed necessary for persons to be removed from their ordinary living situation and placed into specialized facilities, accommodation should provide regular living areas, typical home furnishings, and personal space.

The community is central to the normalization principle. Within each community, mentally handicapped persons should be able to attend regular schools, obtain meaningful employment, and have opportunities to choose leisure activities. To promote the involvement of the mentally handicapped in community activities, and also to ensure that appropriate community resources are used, strong links between all programs providing services for a given individual are necessary. For the integration of behaviorally disturbed persons into the community, the behavioral service system should necessarily collaborate with branches of the generic services (e.g., medical, penal, vocational, educational, etc.).

**C. Goals and Objectives**

The goals and objectives of a comprehensive community behavior services system derive in part from provincial policy issues and in part from the analysis of the needs and resources assessment within the Northwest Region.

1. Goal - To provide support to mentally handicapped individuals with behavior problems to enable them to achieve more normal lives.

Objective - To help clients maintain themselves within appropriate services or to prepare clients for a return to the program from which they were rejected.

Objective - To provide the least restrictive environment/services consistent with client developmental and treatment needs.

Objective - To assist clients in reducing disturbing behaviors and increasing adaptive behaviors.

2. Goal - To emphasize preventive care rather than interventive care.

Objective - To provide consultation, advice, and practical help to families, teachers, and agency personnel who care for clients with behavior problems.

Objective - To provide training and professional development opportunities to rehabilitation staff and other interested groups.

Objective - To provide adequate and efficient follow-up services.

Objective - To evaluate the programs of the behavioral services system on a regular basis.

3. Goal - To participate in the planning and coordination of rehabilitation services.

Objective - To advocate for clients with other social service agencies that may be dealing with them.

Objective - To ensure the acknowledgement and respect of individual rights, such as educational, vocational, legal, etc.

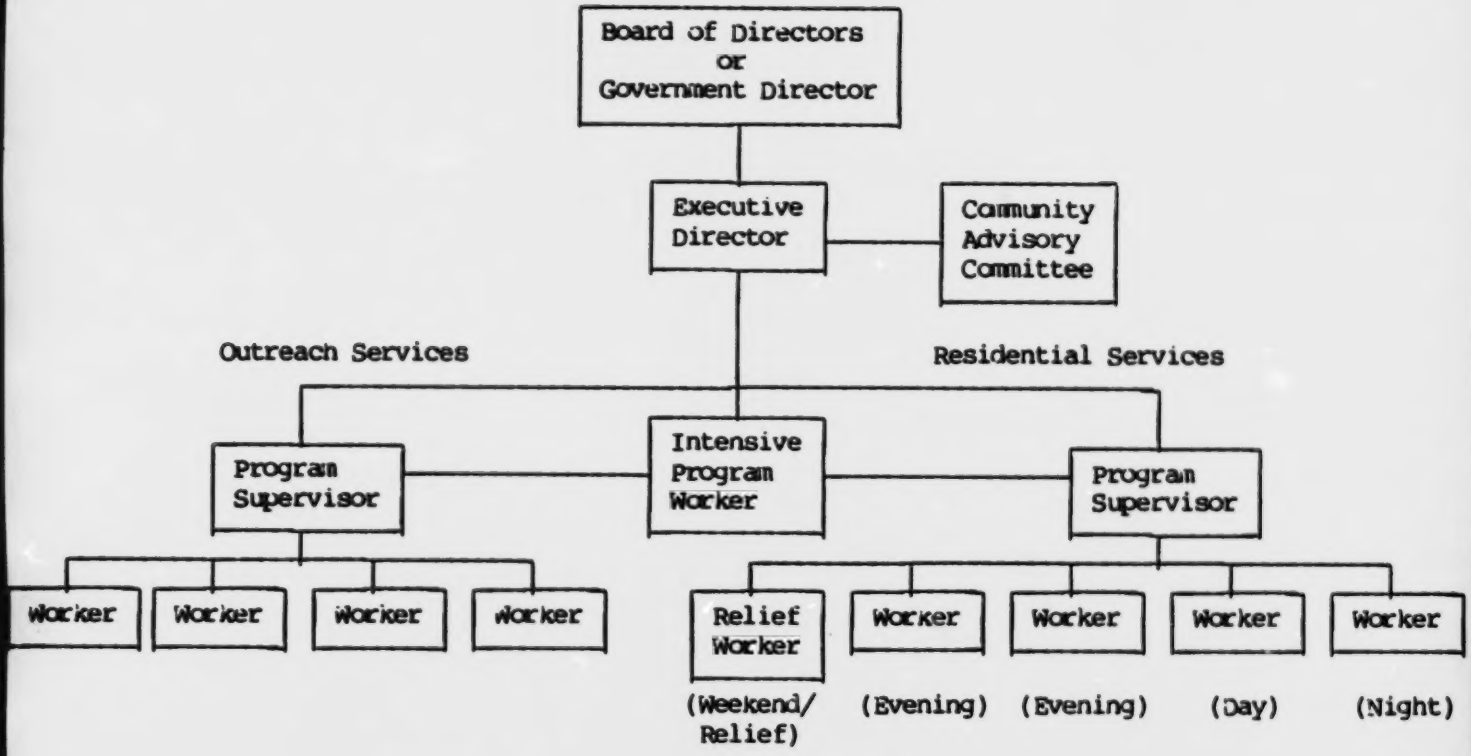
Objective - To link clients to other agencies and/or more appropriate services by referral.

**D. Recommendations for Community Behavior Management Services (CBMS)**

1. An outreach behavior services program should be provided to give assistance to clients and caregivers within a community setting.

Based on the principles of normalization, outreach behavioral support (see Figure 1 for suggested organizational chart) becomes the most important component of a community behavior services system. Its significance derives from providing services to clients that enable them to remain in their existing environment and be self-supporting. Of equal value is the outreach component's role in prevention, through support, consultation, and training to parents and other professionals to help them work with behavior problem individuals in existing settings.

COMMUNITY BEHAVIOR MANAGEMENT SERVICES
NORTHWEST REGION
ORGANIZATIONAL CHART



The survey conducted by WIRTC revealed that Behavior Management Services (BMS) in the Northwest Region currently operated by ASSCH is held in high regard by the agencies who have utilized its services. Results showed that the agency has responded to a variety of needs when requested and has effectively demonstrated that maladaptive behaviors can be reduced or changed and replaced by adaptive behaviors.

However, and notwithstanding the positive results of the survey, community agencies unanimously expressed the critical need for more such services. Presently, BMS comprises two full-time behavior specialists. They provide service to an active caseload that usually ranges in size from 15-20 clients. The survey identified approximately 100 individuals with sufficiently aberrant behaviors to warrant behavioral treatment. Thus there is a gap for behavior management services approximately 4 times the size of the active caseload that BMS now carries.

Various outreach behavior services within Canada and the United States have been identified. Among the programs typically offered are individual treatment/training programs for clients within community environments; intellectual, emotional, and developmental assessments; educational services (workshops, in-services, special courses) for rehabilitation staff; family counselling; and support and consultation to adults charged with the care of mentally handicapped persons regarding behavior management.

Survey responses from organizations in the Northwest Region of Alberta indicated that consultation, in-service training, and assessment services were thought to be most needed in the area. School systems responded somewhat differently, ranking client counselling higher than both consultation and in-service training services. In light of these results, and guided by the goals and objectives for behavioral services previously outlined, the following conclusions were reached.

a) The outreach program should offer a minimum set of services that includes:

- client assessments for designing individual programs and determining appropriate program placement.

- consultation with rehabilitation staff and parents with the goal of decreasing maladaptive behaviors and preventing institutionalization.

- in-service training and workshops to families and agencies.

- direct intervention in the client's own environment.

- follow-up and/or referral services provided after clients are discharged from CBMS.

- evaluation of program effectiveness.

- collaboration with the generic services to facilitate appropriate residential and/or vocational/activity program placements.

b) Five outreach workers should be employed in the region, with active caseloads of 20-25 per worker.

The technology of behavior change programs often requires that intervention/training with clients involve an extensive amount of staff time in order to be effective. Helping an individual reduce a disturbing behavior or to acquire a new skill may necessitate sophisticated and highly structured methods that must be monitored for long periods of time. Thus the staff to client ratio for behavior management services should be high compared to some other types of social services.

Of the approximate 100 mentally handicapped persons with behavior problems identified in the Northwest Region, approximately:

- 30 live in or around the Grande Prairie area
- 26 live in or around the Peace River area
- 17 live in or around the Barrhead area
- 15 live in or around the High Prairie area
- 15 live in or around the Fairview area

Given that only a few of these individuals are receiving behavioral programming at present, there is little chance for a decrease in the number of prospective clients.

There are many staffing models by which outreach services could be provided by workers in the region. In planning for the delivery of services, one must consider such things as geography, client locations, client needs, travel costs in money and time, etc. Following is a brief summary of two staffing models which appear feasible for the Northwest Region.

- One outreach worker each is located in the Grande Prairie, Peace River, McLennan, and Barrhead sub-regions (see Figure 2 for suggested sub-regions). Each worker is responsible for providing outreach services to clients in their respective areas. A program supervisor, located in the Grande Prairie area, is to coordinate services within the outreach team, evaluate service effectiveness, and organize workshops and in-services for agency personnel, parents, and teachers within the entire region.

- Two teams of two outreach workers each are mobile, but based in Grande Prairie. One team is to provide training and support primarily to clients in their home, residential or school/day program environments. The other team is to provide training and support to parents, teachers, rehabilitation staff, and other service agencies. A program supervisor is responsible for coordinating outreach services across teams, evaluating program efficiency and community needs.

2. A 3-4 bed intensive program residence should be provided for individuals whose behavior problems require a structured environment for treatment.

An intensive program residence is a specialized residence where training is structured and supervised. The focus of training is

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to decrease maladaptive behaviors and increase socially appropriate behaviors and functioning skills that enable clients to be integrated into regular community life. The residence is expected to have a stable clientele who contract for services for relatively short time periods (6 months to 1 year).

The results of the needs/resource survey indicated that agencies would require the services of a short-term residential facility on the average of one to three times per year. Comments were noted that 18 individuals in the last 3-1/2 years have had to be transferred out of the region because of lack of facilities and services. Concerns were also expressed that obtaining a residential placement for behavioral services in Edmonton for Northwest clients has taken at least 12 months. In spite of this delay, Community Behavior Services in Edmonton has noted a trend indicating a decreased number of referrals from city residents and an increased number from rural residents in the Edmonton and Northwest Regions.

A suggested location for the residence is the city of Grande Prairie. This is determined largely by its relatively central location and the high availability of related and more sophisticated resources and generic services in the area.

There are several points which should be considered in planning a residential facility.

a) <u>The residence should be available for mentally handicapped individuals 18 years of age and older</u>.

Approximately 50% of clients identified as requiring behavior support/management programs were between the ages of 18 and 45. Similarly reflecting this profile, the majority of agencies contacted expressed the need for an adult behavioral residence rather than a children's residence.

However, one important issue should be noted. In order to attend Crystal Park School, students must live within a reasonable driving distance from it. This has resulted in an increase in the number of mentally handicapped children requiring residential placements in the Grande Prairie area. Unfortunately at present, the supply of residential spaces is not meeting the demand, and many children outside the area are not able to enroll. Concern and need were explicitly expressed for a general residence for handicapped children in the area. In light of these concerns, a potentially growing population of mentally handicapped children in Grande Prairie may soon necessitate an additional behavioral residential facility for children.

b) The residence should not be a locked facility.

The survey data indicate that less than 10% of the behavior problems in the region could be designated as severe. This suggests that a secure residence, i.e., "place of care" (The Dependent Adults Act, 1981), is not necessary. Instead, security should be provided through adequate numbers of residential staff with sufficient training and qualifications to handle potentially volatile residents.

c) The residence should be wheelchair accessible to accommodate those residents who require wheelchairs for mobility.

Steps should be taken to ensure that the residence has such features as ramped or ground level access; hall and door widths of adequate size; one bathroom with roll-in shower stall, room for transfer beside the toilet, adjustable and downward tilting mirror, and grab bars; and light switches, wall outlets, etc. at the height of a seated person (Wilks, 1981).

d) The staffing pattern should maintain appropriate staff levels over a 24-hour period.

It is the aim of the residential program to reduce those behaviors that prevent clients from functioning in regular residential facilities or day programs for the mentally handicapped, and concomit-

antly, to train adaptive behaviors and functional skills. Therefore, program work is expected to be almost continuous. Intensity and nature of programming may vary depending on the particular client's needs, but often require that staff members be available in the residence at all times.

A number of staffing patterns and levels have been identified from the review of existing behavioral residences in North America. Each pattern generally represents a variation of one of two primary staffing models:

- One pattern employs an individual or couple who live continually in the group home. The live-in individuals are not usually on duty during the hours the residents attend school, vocational, or day programs. Trained staff often provide relief for live-in persons on specified weekends and evenings, and in cases of illness of a resident or the live-in persons.

- The other pattern involves staff members on rotating shifts. One shift usually extends through the morning and early afternoon hours, one shift through the late afternoon and evening hours, and one shift through the night-time hours.

There appears to be no discernible difference in the effectiveness of the two models in terms of the treatment/training programs (e.g., Gage, Fredericks, Baldwin, Moore, and Grove, 1978). However, there are several staff-related advantages and disadvantages with each model. The live-in model may present problems in finding trained relief staff during times of vacation or illness. Relief positions are generally not full-time, and often people available for this work are also employed elsewhere in the community. To make sure that relief staff are available for group home staff, it may be necessary to have three or four trained relief staff members on call.

Another potential problem with the live-in model is staff burn-out. Certainly the intensity of programs which live-in operators are asked to conduct creates the high probability that these individuals would not be long-term employees. However, the nature of behavioral residences requires a high client to staff ratio almost by definition, meaning that more than one regular staff member is usually

on duty at all times. These other staff members may also live in the home, but house size and practicality usually mean that these individuals work on a rotating shift basis. The live-in operator may do some treatment and/or be responsible for house maintenance duties.

The problem of coordination within the shift model may be greater than in the live-in model in that all programs must be closely coordinated between up to three work shifts to assure continuity and consistency. This is usually alleviated by a great deal of conference, discussion, and daily review of data. One staff member may be assigned as the "key worker" for each residence. The key worker assumes overall responsibility for that client and acts as her or his advocate. It is also felt that key workers counteract the possible negative effects of shift work on relationships among clients and staff.

Finally, the shift model system may potentially cost more for personnel than the live-in system. While salaries for live-in individuals and shift workers could be comparable, a greater number of permanent staff are generally needed for the shift system. This may increase costs even though the shift model requires less substitutes than does the live-in pattern.

To ensure that structure and consistency are maintained in the treatment/training programs, it is recommended that the direct staff to client ratio be 1:2 in general. During the day, staff levels will be low because residents are attending school or day programs. More intensive staffing is required in the late afternoon and evening hours as well as during weekends when clients are in the residence and when most of the treatment activities are carried out. Depending on the demands and needs of the particular residents, night staff may be required to remain awake while on duty.

It is anticipated that at least 5 direct care workers will be employed per 24-hour period (see Figure 1 - Organizational Chart).

This will provide for: two staff on duty (one day staff, one night staff) in the early morning to assist in preparing breakfasts and ensuring residents travel to day programs on time; two staff members on duty in the late afternoon and evening hours to carry out the training programs; one staff member on duty during the night-time hours and in the early morning to assist with morning preparations of clients. One Program Supervisor can assist in training, consult with staff, and perform the necessary administrative and coordination of treatments.

3. A Community Advisory Committee should be established to ensure the coordination and integration of client services between Community Behavior Management Services and other community and generic services for the mentally handicapped.

a) The membership of this committee should comprise community and government agencies providing services to the mentally handicapped, Outreach and Residential Program Supervisors, Client Services Coordinators, parents, and representatives of educational institutions.

o) Three suggested functions (alternative or in combination) could include:

- admissions/discharge - to review referrals in order to place clients in the appropriate program (outreach, residential, generic).

  This function would ensure that clients are provided with the least restrictive environment possible. Fulfilling this objective also means that clients be moved through approved programs and agencies as functioning levels change.

- advisory/planning - to provide advice and counsel to the program coordinators/supervisors of Outreach and Residential Services.

  This function would serve to maintain and/or initiate consistent and quality services as the needs of residents, staff, and community change.

- research/evaluation - to study the operations of CBMS components in order to evaluate the impact and effectiveness of service delivery, and to conduct research related to services and facilities for mentally handicapped persons with behavior problems.

This function would ensure the review of programs on a regular basis and that relevant information will be collected and analyzed for the benefit of behavioral and related agencies elsewhere.

c) The Committee should be responsible for coordinating the use of contracted professional services available in the community.

Such services could be utilized for the assessment and treatment of clients with psychiatric problems or organic/neurological deficits as well as for the purposes of carrying out research and performing evaluations of service components. Concurrently, through close contact with, and consultative services to, the generic system, CBMS may be able to avoid inappropriate placement of clients who do not fit easily into existing services.

Effective interagency collaboration requires a basic understanding and appreciation of the purpose and functions of each participating agency. This awareness can serve several functions (Hall, 1980). First, it expands the resource knowledge of the service providers in order that a more effective and meaningful continuum of services be available. Second, it reduces the time and energy that consumers must devote to obtaining effective services.

Increasing the linkages between agencies also requires that the different staffs view one another as collaborators, rather than as competing protagonists. "Territorial" or "turf" concerns, clearly evidenced among many agencies, represents a sensitive issue. Service systems tend to profess, defend, and justify their activities with the primary intention of self-perpeuation and survival. While one can find fault with this process, the motivation is relatively legitimate. For the most part, service agencies are staffed by individuals who like to provide, and gain recognition for, quality services. Therefore, interagency policy agreements should ultimately reflect a recognition of those services which a particular agency already is known for providing and providing well.

4. An Intensive Program Worker should be available for intensive, direct treatment/training, when necessary, within or in place of the client's day program.

Many group homes and vocational centres for the mentally handicapped have indicated that behavior problems are typically handled through outside assistance for staff in designing and implementing change programs. Some agencies have reported that clients must be terminated because staff do not have the specific expertise to deal with the presenting behavior problems, or because the staff to client ratio is not sufficient to allow the required constant supervision for certain clients.

Several operators of community agencies have expressed a willingness to integrate behavior problem clients within their programs provided extra behavioral support personnel are assigned as deemed necessary. It is suggested that CBMS could provide this program support upon request. This would enable the client to continue in the day program if appropriate and would provide agency staff with opportunities to acquire some behavior management techniques. In addition, through collaboration with school systems, direct tutoring coordinated with behavior management might be provided.

5. The staff of CBMS should consist of individuals with above-average skills in assessment, behavioral intervention, and individual program planning.

Ensuring that those responsible for the treatment/training of clients can readily carry out the techniques to achieve the desired behavior changes presents by far the greatest obstacle to behavior management services for rural clients. Social and cultural isolation, extreme weather conditions, and low salaries are some of the factors that often deter qualified individuals from obtaining and maintaining employment in rural areas (Helge, 1981). These are problems facing

many rural employers, but can be compounded when the people to be served experience multiple handicaps and exhibit maladaptive behaviors.

The results of the present Northwest Region survey indicated that approximately 70% of the agencies contacted presently employ staff with some behavior management training. At one end of the training continuum are individuals with high school diplomas who have taken at least one workshop/training course dealing with general behavior management and/or specific treatment strategies. Other individuals have obtained Rehabilitation Practitioner, Special Education, Social Work and related diplomas, in which courses in behavior modification or related skills are required. University degrees (e.g., B.Ed., B.A., M.A.) form the other end of the training continuum.

Staffing a behavior management service would require that personnel possess expertise in many areas. Knowledge of assessment, time management, behavioral intervention, professional report writing, and monitoring client progress would be necessary. In addition, the ability to work with stress and frustration would be required at a level greater than that typically held by service providers in other facilities. In each of the province's behavioral services currently operated by Alberta Social Services and Community Health, a Rehabilitation Practitioner diploma is a minimum requirement for staff. Within the Northwest Region there are several means of providing the necessary qualified staff for behavioral services.

i. Rehabilitation Practitioner diploma - Grande Prairie Regional College

Presently in the Northwest Region, several major service organizations and interested individuals associated with the mentally handicapped are working together in the needs assessment and development of a Rehabilitation Practitioner program at the Grande Prairie Regional College. Rehabilitation Practitioner (R.P.) diplomas are

presently offered by four Alberta colleges: Grant MacEwan Community College (Edmonton), Mt. Royal College (Calgary), Lethbridge Community College, and Red Deer Community College. Noticeably absent from the general areas served by these institutions is Alberta's Northwest Region. This undoubtedly contributes in part to the fact that while 77% of the agencies surveyed reported that attempts have been made to hire staff with specific behavior management training, only 39% reported that they are usually successful in doing so.

An R.P. program would graduate individuals with the competency to design, implement, and evaluate programs with an emphasis on teaching specific skills to the developmentally disabled. The value of such a program at the College lies in providing the local communities with sufficiently qualified staff who, because they currently reside in the area, presumably would present a high probability of remaining to work in the area.

ii. Training by Outreach Behavioral Services

The Outreach component of CBMS could provide behavior management lectures/workshops/courses designed to train potential staff to work within the Service's objectives and goals. This would necessitate that several outreach staff have sufficient qualifications and expertise in educating future trainers in behavior modification techniques. In addition to training for positions in rehabilitation and behavior management, training in behavioral techniques could benefit a number of other groups in the community. One group is parents who wish to learn particular strategies to deal with their children's daily behavior. A second group is teachers who often need classroom techniques to maximize student behavior change.

iii. Scholarship/Service Program

Scholarships could be provided for individuals enrolled in Rehabilitation Practitioner programs which already exist in exchange for two years of service in an agency/facility chosen by the scholarship provider. This type of program would ensure that qualified

personnel are available to many areas where recruitment may be difficult. It also provides the individual with an immediate job upon graduation in which he/she can obtain necessary and beneficial job experience.

iv. Salary & Benefits Package

Given the difficulty of retaining and recruiting qualified staff in rural areas (Helge, 1981), a number of "job perks" can be offered to prospective applicants. Benefits might include high salaries relative to more urban areas, housing allowances, medical and/or life insurance coverage, moving supplements, etc.

6. The application of telecommunications technologies to home behavior management of mentally handicapped children and their parents should be explored.

Delivery of services is made multiply difficult when handicapped persons are located in sparsely populated areas, or in areas which are isolated by geographic barriers. The development of telecommunications systems represents a logical strategy to circumvent these and other such problems. Telecommunications systems offer a variety of ways to link homes in remote locations with a central organizational/resource unit. Telephone or television transmission systems can provide daily services often of a higher quality than that provided by present itinerant, homebound services.

The WIRTC survey indicated that agencies were in favor of telecommunications being utilized more for support services to parents and rehabilitation staff than for direct client counselling. In instances where some parents and/or agency personnel have requested behavior management training, but because their numbers are small and they are located throughout the entire region it is not feasible to require them to gather at one location, training courses could be offered either through cable TV channels, teleconferencing, or computer terminals placed in sub-areas of the region and connected to

a central resource unit. Other functions suggested for telecommunications were providing emergency contacts, frequent monitoring of on-going programs, regular but relatively infrequent contracted services such as those of a neuropsychologist, and agency liason teleconferencing.

The major characteristics of several prototype systems illustrate present capacity to provide services to the mentally handicapped:

- a telecommunications network links a resource centre, homes, local program monitors, and a health service unit by standard telephone equipment with interactive speakers (Homebound Handicapped Resource Centre, Utah). Once identified by local monitors, parents are sent instructional packages which are designed to assist them in teaching various skills to their children. The interactive telephone speaker system is used to report children's progress, to solve instructional or programming errors, and to assist parents in solving management problems.

- films to teach language concepts to mentally retarded children and/or children with severe behavior disorders are presented on a responsive television system - a standard television set which has been modified by the addition of an electronic switching device (Teaching Resources Centre, New York). The video programs can be used over the air or on cable systems.

- professional quality video tapes are designed to provide illustrations of methods for teaching a discrete behavior (Purdue University Achievement Centre for Children). These are transmitted over local television stations, and parents are given a schedule indicating when programs specific to their child's needs will be shown. After the videotape, parents interact through a telephone link to the studio, which also allows them the opportunity to hear each others' questions and concerns.

- a computer/client interactive television system delivers instruction to individuals in their home environments (New York State Department of Education). Specific curriculum programs are designed, stored in the computer's memory, and can be called up as deemed necessary. The system works in the following manner: the student dials the computer center,

places the telephone in an acoustic coupler, and types a message on the teletype keyboard. The program requested is transmitted over the cable TV system and appears on the television set.

**E. Capital and Operating Expenditures**

1. Residential Facility

a) Capital Costs (as projected by area realtors)

Estimated total area: 195$m^2$ (2000 $ft^2$)

| | |
|---|---|
| - land purchase | $25,000.00 |
| - construction | $96,000.00 |
| - design fees | $30,000.00 |
| - furnishings | $35,000.00 |
| - food & household supplies | $11,000.00 |
| Total | $197,000.00 |

b) Facility costs (as projected by Northwestern Utilities, Alberta Power, and the City of Grande Prairie Water & Tax Departments)

| | |
|---|---|
| - yearly taxes | $ 1,800.00 |
| - utilities | $ 3,400.00 |
| - liability & building insurance | $ 1,000.00 |
| Total | $ 6,200.00 |

c) Other operating costs (based on current residential facility budgets)

| | |
|---|---|
| - maintenance & repair of land, building, furniture (contracted) | $ 5,000.00 |
| - housekeeping | $ 2,400.00 |
| - training materials | $ 5,000.00 |
| - administration & office supplies | $11,000.00 |
| Total | $23,400.00 |

d) Staffing costs (based on ASSCH salary guidelines)

| | |
|---|---|
| - Program Supervisor | $30,000.00 |
| - Residential Workers (5) | $125,000.00 |

| | |
|---|---|
| - Clerical Support (1) | $16,000.00 |
| - Staff Development | $ 5,000.00 |
| - Travel | $ 2,000.00 |
| - Benefits | $17,000.00 |
| Total | $195,000.00 |
| Estimated total cost for residential program: | $421,600.00 |

2. Outreach Program

a) Capital costs (as projected by area realtors).

| | |
|---|---|
| - Yearly office rental (approx. 5 offices 120 sq.ft./office) - $7.00/sq.ft. | $ 4,200.00 |
| - furnishings | $10,000.00 |
| Total | $14,200.00 |

b) Operating costs.

| | |
|---|---|
| - long distance telephone charges | $28,000.00 |
| - maintenance (contracted) | $ 2,400.00 |
| - training materials | $10,000.00 |
| - administration & office supplies | $13,000.00 |
| Total | $53,400.00 |

c) Staffing costs (based on ASSCH salary levels).

| | |
|---|---|
| - Program Supervisor | $30,000.00 |
| - Outreach Workers (4) | $100,000.00 |
| - Clerical Support (1) | $16,000.00 |
| - Staff Development | $10,000.00 |
| - Travel | $15,000.00 |
| - Benefits | $14,000.00 |
| Total | $185,000.00 |
| Estimated total costs for outreach program | $252,600.00 |

| | |
|---|---|
| 3. Administration & other costs. | |
| - Executive Director | $38,000.00 |
| - Accounting (contracted) & | $20,000.00 |
| Public Information Materials | $ 2,500.00 |
| - Intensive Program Worker | $25,000.00 |
| Total | $85,500.00 |

| | |
|---|---|
| Estimated Total Costs | $759,700.00 |

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APPENDIX A - Letter of enquiry for national survey of behavior management services

Director

Dear Sir:

In cooperation with a parent association for individuals who are mentally disabled, Western Industrial Research and Training Centre is developing a model for a comprehensive, community-based behavior management program to serve both children and adults within the northwest region of Alberta. This region is a predominantly rural area of some 90,000 square kilometres and inhabited by fewer than 100,000 people. Major components of the service under consideration include outreach programs offering direct service to individuals exhibiting behavior problems that prevent successful functioning in the community, as well as consultation to parents, teachers, group home staff, or other service providers, and facility-based residential or day programs offering time-limited services.

As part of the initial process of developing this model, we are writing to a number of human services agencies and associations for persons with mental and/or emotional disabilities across Canada to request information on similar types of services that they may be providing to their local communities. If your agency provides any of the above mentioned services to children and adults with mental disabilities, please help us by sending any materials you have describing your program.

Although any materials describing your agency and its services would be helpful and appreciated, we are particularly interested in information with respect to organizational structure, operating procedures— outreach and residential, program content, referral and assessment systems, consultation and ecucational programs, evaluation methods, and integration with other community agencies and services.

In addition, we are asking you to send us the names and addresses of other local human service agencies and association that might provide us with relevant information.

Thank you in advance for your cooperation and help in this matter. We look forward to hearing from you soon.

Sincerely,

Steven S. Dennis, Ph.D.
Vice-President Research

SSD

Encl.

Agency: _____

Address: _____

_____

_____

Agency: _____

Address: _____

_____

_____

Agency: _____

Address: _____

_____

_____

Agency: _____

Address: _____

_____

_____

APPENDIX C - Regional and district area map:

Alberta Social Services and Community Health

BEST COPY AVAILABLE

APPENDIX D - Survey questionnaires for residential centres, school systems, vocational rehabilitation centres, and government social services

# NEEDS/RESOURCE SURVEY

# FOR

# RESIDENTIAL CENTERS

Date: _____ Interviewer: _____

Agency Name: _____

Address: _____

_____

Phone: (  ) _____

Director: _____

Questionnaire Respondent: _____

Position: _____

## A. AGENCY SERVICES

1. What is the total number of current residents? _____

   How many spaces are available? Permanent_____Temporary_____

2. Please provide a brief statement of program goals or objectives.

   _____

   _____

   _____

   _____

3. Do you assist residents to become independent? _____

   _____

   _____

   _____

   _____

4. Please indicate services provided and specify.

a) _____ Lifeskills _____

_____

_____ Academic Programming _____

_____

_____ Recreational Programming _____

_____

_____ Vocational Programming _____

_____

_____ Interpersonal skills development _____

_____

_____ Counselling _____

_____

_____ Other _____

_____

5. Please specify entrance and exit criteria. _____

_____

_____

_____

_____

6. Do you expect to <u>increase</u> or <u>decrease</u> services in the next 3 years? (Please circle one)

If so, in what program areas and will the number of clients served be changed? _____

_____

_____

_____

B. **CLIENT POPULATION**

1. Population Description

Age Range: _____years to_____years Average age: _____years

Please indicate the primary disability and number of individuals in each of the following categories.

Mentally Disabled

_____ Profound _____ Severe _____ Moderate

_____ Mild

_____ Psychiatric: Please specify nature of disabilities. ___

_____

_____

_____

_____ Physically Disabled: Please specify nature of disabilities. _____

_____

_____

_____

_____ Visually Impaired

_____ Multiple Dependent Handicap

_____ Other, please specify. _____

_____

_____

_____

_____

2. a) What is the average length of stay by clients? _____years

b) Why? _____

_____

C. **BEHAVIOR SERVICE NEEDS**

1. Using the following categories, how many individuals have exhibited behavioral problems in the past 12 months. Definitions are attached.

| | Internal | External | Total |
|---|---|---|---|
| Mild | | | |
| Moderate | | | |
| Severe | | | |

2. As far as you are aware, the percentage of behavior problems you experience are:

   a) i. confined to the facility _____%

      ii. appear in other settings as well as the facility _____%

   b) i. appear to originate in the facility _____%

      ii. appear to originate elsewhere _____%

3. How do you currently resolve behavior problems at the residence? Rank order from most likely alternative (1) to least likely intervention strategies. (Use N/A - not applicable where appropriate).

| | | SEVERITY | | |
|---|---|---|---|---|
| | | Mild | Moderate | Severe |
| a) | Termination from program. | | | |
| b) | Referral to other service but continues in program. (indicate agency and contact person below) | | | |
| c) | Seek consultation for staff to implement change program. (indicate agency and contact person below) | | | |
| d) | Design and implement own change program without external assistance. | | | |
| e) | Monitor situation, no intervention unless necessary (too serious to ignore) | | | |

f) Other: please specify

_____

_____

_____

_____

For items B and C above, please specify referral agency and contact person.

b) _____

_____

c) _____

_____

4. Do you presently use the Behavior Management Services provided by Alberta Social Services and Community Health?

_____

_____

a) What services do they provide you?

_____

_____

_____

_____

b) How well are your needs met?

_____

_____

_____

_____

5. What type of community behavior service, if any, would you utilize if it were available? Rank order from the most important (1) to the least important (7).

Client Assessment _____ Staff Consultation _____

Client Counselling _____ In-service Training _____

Short Term Residential (Children and/or adults) _____

Information Packages _____

Staff Consultation _____ Other: please specify

_____

_____

_____

6. How frequently would you likely use these services in the course of 12 months?

Adult Assessment _____

Client Counselling _____ In-service Training _____

Short Term Residential (Children and/or adults) _____

Information Packages _____

Staff Consultation _____ Other: please specify

_____

_____

_____

7. Briefly describe the nature or content of the service you would like to have available for each of the following service categories?

a) Client Assessment (e.g., type of assessment information)

_____

_____

_____

_____

_____

_____

b) Client Counselling (e.g., nature of counselling needs)

_____

_____

_____

_____

_____

_____

c) Short-Term Residential (e.g., location, length of staff, type of program offered)

d) Staff Consultation (in person)

e) In-Service Training (e.g., workshops or other educational opportunities)

f) Information Packages

g) Other

8. Do you anticipate a growing need for behavior management services? If so, in what areas and why?

D. **STAFFING**

1. Please indicate the number of staff in each area and briefly describe their major role(s).

_____Social Worker

_____

_____Rehabilitation Practitioner

_____

_____Academic Staff

_____

_____Vocational Staff

_____

_____Housekeeping

_____

_____Other, please specify _____

_____

_____

2. Please describe your organizational and staffing model (e.g., government versus private, board of directors, operator versus shift work model). _____

_____

_____

_____

_____

_____

_____

_____

_____

3. Staff Qualifications

a) Please indicate the number of staff in each category.

| | Completed | Partial |
|---|---|---|
| High school diploma | | |
| College degree in field (e.g., rehab. practitioner) | | |
| College degree not in field | | |
| B.A. | | |
| M.A. | | |

b) What is the average number of years of experience in the field?

_____

c) What is the average staff turnover period.?

_____

4. How many staff members have specific training in behavior change program design or other intervention strategies for behavior problems?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

5. Have you sought to hire staff who have expertise in behavior change programs or related skills?

6. Are you able to hire staff with expertise in behavior change programs or related skills. Why?

7. How many in-services, seminars or workshops have residential staff attended in the past 12 months?

____Number of staff

____Number of training sessions

____Topics: (Please specify several examples)

**E. EVALUATION**

1. How do you evaluate the effectiveness of your service? (e.g., personnel evaluation, treatment programs, consumer [parents, teachers] validation?

2. Do you evaluate the effects of any active treatment programs on the client's behavior or performance outside of the residential setting? If yes, please specify.

3. Do you follow-up clients following discharge? If so, what is the procedure and follow-up period?

F. **FUNDING**

1. How is the residence funded? (sources, etc.)

2. What is the cost of the residential program? Include in this estimate separate costs for staffing, overhead, etc. It would be very helpful to know the current salary ranges for residential staff.

G. **FACILITY**

1. Please describe your residential facility.

Size_____

No. of Rooms_____Client Bedrooms_____Staff Bedrooms_____

Dining Room_____Bathrooms_____Living Room_____

Recreational Room_____Other staff only rooms_____

Other, please specify _____

_____

2. Is your facility wheelchair accessible? _____

3. Are there any special features in your residence? Please describe. _____

_____

_____

_____

4. If you could modify this facility, what would you do? _____

_____

_____

_____

5. How do you maintain good public relations with the community?

During development stage: _____

_____

_____

_____

Currently: _____

_____

_____

_____

6. Do you have any other comments regarding concerns or needs for a community behavior management service?

Additional Comments:

**DEFINITIONS**

**Behavior Disorder**

| | |
|---|---|
| * Socially inappropriate but not usually disruptive to other people. (e.g., self-stimulation)<br>* Generally compliant. | * Mildly disruptive to others, non-violent but annoying interpersonal behavior. (e.g., inappropriate expression of affection) |
| * Tendency to withdrawal and non-compliance, behavior interferes with training.<br>* Lack of motivation.<br>* Apparent unwillingness to change. | * Socially offensive behavior, tendency to be uncooperative and emotionally reactive if provoked.<br>* Minor offenses. (e.g., theft) |
| * Dangerous to self, otnen suggestive of psychiatric disorder.<br>* Necessitates immediate intervention.<br>* Complete lack of appropriate social behavior, tends to be highly disruptive. | * Hurtful to others, destructive to property, violent emotional outbursts, verbally or physically abusive.<br>* Highly disruptive to others. |

# NEEDS/RESOURCE SURVEY

# FOR

# SCHOOL SYSTEMS

Date: _____ Interviewer: _____

School System: _____

Address: _____

_____

Phone: ( ) _____

Superintendent: _____

Questionnaire Respondent: _____

Position: _____

Please request and attach school brochures or otner documentation.

## A. BEHAVIOR SERVICE NEEDS

1. Do you have mentally handicapped students with behavior problems?

Yes _____ No _____

2. Student Description

Age range of students with disabilities

| Elementary | Secondary |
|---|---|
| _____ years to _____ years | _____ years to _____ years |
| Average age _____ years | Average age _____ years |

Please indicate the primary disaoility and number of individuals in each of the following categories:

| | Elementary | Secondary |
|---|---|---|
| Mild | | |
| Moderate | | |
| Severe | | |
| Profound | | |

| | Elementary | Secondary |
|---|---|---|
| Psychiatric/Emotional | | |
| Physically Disabled | | |
| Visually Impaired | | |
| Multiple Dependent Handicap | | |
| Other, Please specify | | |

3. Using the following categories, how many students have exhibited behavioral problems in the past 12 months. Definitions are attached.

| | Internal | External | Total |
|---|---|---|---|
| Mild | | | |
| Moderate | | | |
| Severe | | | |

4. As far as you are aware, what percentage of behavior problems you experience are:

a) i. confined to the school _____%
ii. appear in other settings as well as the school _____%

b) i. appear to originate in the school _____%
ii. appear to originate elsewhere _____%

5. How do you currently resolve behavior problems in the school? Rank order from most likely alternative (1) to least likely intervention strategies.

| | Mild/Moderate | Severe |
|---|---|---|
| a) expelled from school | | |
| b) suspension/detention | | |
| c) transfer to another school | | |
| d) referral to outside service but continues in school | | |
| e) seek consultation for staff | | |
| f) referral to school psychologist or counselor | | |
| g) design and implement own program | | |
| h) monitor situation (same as others) | | |
| i) other; please specify | | |

For items c, d and e please specify referral agency and contact person.

c) _____

d) _____

e) _____

6. Do you presently use the Behavior Management Services provided by Alberta Social Services and Community Health?

_____

_____

_____

_____

a) What services do they provide you?

_____

_____

_____

_____

b) How well are your needs met?

_____

_____

_____

_____

7. What type of community behavior service, if any, would you utilize if it were available? Rank order from the most important (1) to the least important (7).

Assessment _____ Staff Consultation (teleconferencing)____

Student Counselling _____ In-service Training _____

Short Term Residential _____ Information Packages _____

Staff Consultation (on site) _____ Other: please specify

_____

_____

_____

_____

8. How frequently would you likely use these services in the course of 12 months.

Assessment _____ Staff Consultation (teleconferencing)_____

Student Counselling _____ In-service Training _____

Short Term Residential _____ Information Packages _____

Staff Consultation (on site) _____ Other: please specify

_____

_____

_____

_____

9. Briefly describe the nature or content of the service you would like to have available for each of the following service categories?

a) Assessment (e.g., type of assessment information)

_____

_____

_____

_____

_____

_____

b) Student Counselling (e.g., nature of counselling needs)

_____

_____

_____

_____

_____

_____

c) Short-Term Residential (e.g., location, length of staff, type of program offered)

d) Staff Consultation (in person)

e) Staff Consultation (teleconferencing)

f) In-Service Training (e.g., workshops or other educational opportunities)

g) Information Packages

h) Other

10. Do you think your school system might benefit from a behavior management service? If so, in what ways would tney be of benefit?

_____

_____

_____

_____

_____

11. Do you anticipate a growing need for behavior management services? If so, in what areas and why?

_____

_____

_____

_____

_____

B. **STAFFING AND EDUCATIONAL PROGRAMS**

1. Please indicate the number of staff employed in educational programs for students with handicaps.

| | Elementary | Secondary |
|---|---|---|
| Teaching (academic) | | |
| Teaching Aids | | |
| Teaching (vocational) | | |
| Counselling | | |
| Combined teaching/counselling | | |
| Psychologist | | |
| Other, please specify | | |
| | | |

2. How many staff members have specific training in behavior management?_____

3. Do you offer special classes for persons with disabilities? If so, please describe. _____

_____

_____

_____

4. Do you receive Educational Opportunity Funding (EOF)?

Yes _____ No _____

If yes, please describe the program: _____

_____

_____

_____

_____

_____

5. Do you employ Individual Education Programming (IEP)?

Yes _____ No _____

If yes, please describe: _____

_____

_____

_____

_____

_____

6. Do you attempt to hire staff with expertise in behavior change programs or related skills? If so, are you able to hire staff?

_____

_____

_____

_____

7. Have your staff sought additional training in behavior management in the past 12 months? If so, how many in-services, seminars or workshops related to behavior management have school personnel attended?

____ Number of staff

____ Number of training sessions

8. Do you have any other comments regarding concerns or needs for a community behavior management service?

**Additional Comments:**

# NEEDS/RESOURCE SURVEY

# FOR

# VOCATIONAL REHABILITATION FACILITIES

Date: _____ Interviewer: _____

Agency Name: _____

Address: _____

_____

Phone: ( ) _____

Director: _____

Questionnaire Respondent: _____

Position: _____

Please request and attach agency brochures or other documentation.

## A. AGENCY SERVICES

1. Indicate services provided and number of spaces for the current fiscal year.

a) _____ Activity Program: _____spaces

_____ Work Adjustment or Vocational Training: _____spaces

_____ Rehabilitation: _____spaces

_____ Other: please specify: _____

_____

b) Please provide a brief statement of program goals or objectives. _____

_____

_____

_____

2. Specify Related Services

_____ Job Placement _____ Counselling

_____ Prevocational (placement) training

_____ Skill Training

_____ Behavioral unit

_____ Other: please specify: _____

_____

_____

3. Please specify entrance and exit criterion. _____

| | Entrance | Exit |
|---|---|---|
| Activity | | |
| | | |
| | | |
| Work Adjustment | | |
| | | |
| | | |
| Rehabilitation | | |
| | | |
| | | |
| | | |

4. Do you expect to expand your services in the next 3 years? _____

If so, in what program areas and how many more clients will be served? _____

_____

_____

## B. CLIENT POPULATION

1. Population Description

Age Range: _____years to_____years Average age: _____years

Please indicate the primary disability and number of individuals in each of the following categories. _____

Mentally Disabled

_____ Profound _____ Severe _____ Moderate

_____ Mild

_____ Psychiatric: Please specify nature of disabilities. ___

_____

_____

_____ Physically Disabled: Please specify nature of disabilities. _____

_____

_____

_____ Visually Impaired

_____ Multiple Dependent Handicap

_____ Other, please specify. _____

_____

2. Resident Status

Please indicate number of individuals in each category.

_____ Independent ____Family Residence/Relatives ____Group Home

_____ Approved Home

_____ Other, please specify. _____

_____

_____

_____

3. What distances are travelled by clients from their residence to attend the program. Please indicate number of individuals in each category.

_____ 1-10km._____11-20km. _____ 21-30km. _____ 31-40km.

_____ 41-50km. 51 and more km. _____

If greater than 51 km., provide details. Location and number of individuals. _____

_____

_____

_____

C. **BEHAVIOR SERVICE NEEDS**

1. Using the following categories, how many individuals have exhibited behavioral problems in the past 12 months. Definitions are attached.

| | Internal | External | Total |
|---|---|---|---|
| Mild | | | |
| Moderate | | | |
| Severe | | | |

2. As far as you are aware, what percentage of behavior problems you experience are:

   a) i. confined to the facility _____%

      ii. appear in other settings as well as the facility _____%

   b) i. appear to originate in the facility _____%

      ii. appear to originate elsewhere _____%

3. How do you currently resolve behavior problems at the facility? Rank order from most likely alternative (1) to least likely intervention strategies.

| | | SEVERITY | | |
|---|---|---|---|---|
| | | Mild | Moderate | Severe |
| a) | Termination from program. | | | |
| b) | Referral to other service but continues in program. (indicate agency and contact person below) | | | |
| c) | Seek consultation for staff to implement change program. (indicate agency and contact person below) | | | |
| d) | Design and implement own change program without external assistance. | | | |
| e) | Monitor situation, no intervention unless necessary (too serious to ignore) | | | |

f) Other: please specify

_____

_____

_____

_____

For items B and C on page 6, please specify referral agency and contact person.

b) _____

_____

c) _____

_____

4. Do you presently use the Behavior Management Services provided by Alberta Social Services and Community Health?

_____

_____

_____

_____

a) What services do they provide you?

_____

_____

_____

_____

b) How well are your needs met?

_____

_____

_____

_____

5. What type of community behavior service, if any, would you utilize if it were available? Rank order from the most important (1) to the least important (7).

Adult Assessment _____ Staff Consultation (teleconferencing)____

Client Counselling _____ In-service Training _____

Short Term Residential _____ Information Packages _____

Staff Consultation (on site) _____ Other: please specify

_____

_____

_____

_____

_____

_____

_____

6. How frequently would you likely use these services in the course of 12 months.

Adult Assessment _____ Staff Consultation (teleconferencing)____

Client Counselling _____ In-service Training _____

Short Term Residential _____ Information Packages _____

Staff Consultation (on site) _____ Other: please specify

_____

_____

_____

_____

_____

_____

_____

7. Briefly describe the nature or content of the service you would like to have available for each of the following service categories?

a) Adult Assessment (e.g., type of assessment information)

b) Client Counselling (e.g., nature of counselling needs)

c) Short-Term Residential (e.g., location, length of staff, type of program offered)

d) Staff Consultation (in person)

e) Staff Consultation (teleconferencing)

f) In-Service Training (e.g., workshops or other educational opportunities)

g) Information Packages

h) Other

8. Do you anticipate a growing need for behavior management services? If so, in what areas and why?

D. **STAFFING**

1. Please indicate the number of staff in each area.

_____Training/Program Instructors

_____Manufacturing/Production Personnel

_____Combined Training/Production Positions

_____Job Placement Specialists

_____Other, please specify _____

_____

_____

_____

_____

_____

2. Staff Qualifications/Training Staff Only

a) Please indicate the number of staff in each category.

| | Completed | Partial |
|---|---|---|
| High school diploma | | |
| College degree in field (e.g., rehab. practitioner) | | |
| College degree not in field | | |
| B.A. | | |
| M.A. | | |

b) What is the average number of years of experience in the field.

_____

_____

c) What is the average staff turnover period.

_____

_____

3. How many staff members have specific training in behavior change program design or other intervention strategies for behavior problems?

4. Have you sought to hire staff who have expertise in behavior change programs or related skills?

5. Are you able to hire staff with expertise in behavior change programs or related skills.

6. How many in-services, seminars or workshops have training staff attended in the past 12 months?

____Number of staff

____Number of training sessions

E. **EVALUATION**

1. How do you evaluate the effectiveness of behavior change programs or any intervention strategy?

Do you have any other comments regarding concerns or needs for a community behavior management service?

**Additional Comments:**

**DEFINITIONS**

**Behavior Disorder**

| | |
|---|---|
| * Socially inappropriate but not usually disruptive to other people. (e.g., self-stimulation)<br>* Generally compliant. | * Mildly disruptive to others, non-violent but annoying interpersonal behavior. (e.g., inappropriate expression of affection) |
| * Tendency to withdrawal and non-compliance, behavior interferes with training.<br>* Lack of motivation.<br>* Apparent unwillingness to change. | * Socially offensive behavior, tendency to be uncooperative and emotionally reactive if provoked.<br>* Minor offenses. (e.g., theft) |
| * Dangerous to self, othen suggestive of psychiatric disorder.<br>* Necessitates immediate intervention.<br>* Complete lack of appropriate social behavior, tends to be nighly disruptive. | * Hurtful to others, destructive to property, violent emotional outbursts, verbally or physically abusive.<br>* Highly disruptive to others. |

NEEDS/RESOURCE SURVEY

FOR

MENTAL HEALTH CENTRES

Date: _____ Interviewer: _____

Centre: _____

Address: _____

_____

Phone: (  ) _____

Director: _____

Questionnaire Respondent: _____

Position: _____

Please request and attach centre brochures or other documentation.

A. BEHAVIOR SERVICE NEEDS

1. Do you serve mentally handicapped persons with behavior problems?

Yes _____ No _____

2. Client Description

Age range of mentally handicapped clients

| Children | Adolescents | Adults |
|---|---|---|
| ____years to____years | ____years to____years | ____years to____years |
| Average age ____years | Average age ____years | Average age ____years |

Please indicate the primary disability and number of individuals in each of the following categories:

| | Children | Adolescents | Adults |
|---|---|---|---|
| Mild | | | |
| Moderate | | | |
| Severe | | | |
| Profound | | | |
| Multiple Dependent Handicapped | | | |

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3. Using the following categories, how many clinets have exhibited behavioral problems in the past 12 months. Definitions are attached.

| | Internal | External | Total |
|---|---|---|---|
| Mild | | | |
| Moderate | | | |
| Severe | | | |

4. As far as you are aware, what percentage of behavior problems you experience are:

   i. confined to the school _____%
   ii. confined to the home _____%
   iii. confined to the workplace _____%
   iv. appear in all settings _____%
   v. other _____%

5. How do you currently resolve behavior problems in the centre? Rank order from most likely alternative (1) to least likely intervention strategies.

| | Mild/Moderate | Severe |
|---|---|---|
| a) referral to another counselling agency | | |
| b) seek consultation for staff to implement program | | |

| | Mild/Moderate | Severe |
|---|---|---|
| c) design and implement own program | | |
| d) monitor situation | | |
| e) other; please specify | | |

For items a and b please specify referral agency and contact person.

a) _____

b) _____

6. Do you presently use the Behavior Management Services provided by Alberta Social Services and Community Health?

_____

_____

_____

_____

_____

a) What services do they provide you?

_____

_____

_____

_____

b) How well are your needs met?

_____

_____

_____

_____

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7. What type of community behavior service, if any, would you utilize if it were available? Rank order from the most important (1) to the least important (7).

Assessment _____ Staff Consultation (teleconferencing)_____

Student Counselling _____ In-service Training _____

Short Term Residential _____ Information Packages _____

Staff Consultation (on site) _____ Other: please specify

_____

_____

_____

8. How frequently would you likely use these services in the course of 12 months.

Assessment _____ Staff Consultation (teleconferencing)_____

Student Counselling _____ In-service Training _____

Short Term Residential _____ Information Packages _____

Staff Consultation (on site) _____ Other: please specify

_____

_____

_____

_____

9. Briefly describe the nature or content of the service you would like to have available for each of the following service categories?

a) Assessment (e.g., type of assessment information)

_____

_____

_____

b) Student Counselling (e.g., nature of counselling needs)

c) Short-Term Residential (e.g., location, length of staff, type of program offered)

d) Staff Consultation (in person)

e) Staff Consultation (teleconferencing)

f) In-Service Training (e.g., workshops or other educational opportunities)

g) Information Packages

h) Other

B. **AGENCY SERVICES**

1. Please provide a brief statement of goals or objectives?

_____

_____

_____

_____

_____

_____

2. Specify services concerning mentally handicapped persons with behavior problems.

_____Counselling_____

_____

_____Family Counselling_____

_____

_____Behavior Day Program_____

_____

_____Information/Referral Services_____

_____

_____Outreach Services_____

_____

_____Workshops for parents, school personnel, etc.

_____Home visits for behavior change programs.

_____Consultation for individuals caring for the mentally handicapped with behavior problems.

_____Other: _____

_____

_____

3. To be answered by those agencies offering outreach services for behavior problems in mentally handicapped persons:

a) How frequently do you visit a client's home, workplace, school (on the average)? _____

b) Under what circumstances would you provide such outreach services (as opposed to office visits)? _____

_____

_____

c) How well do you think the outreach programs work in modifying behavior (again versus counselling in your offices)? _____

_____

_____

_____

_____

C. STAFFING

1. Please indicate the number of staff employed in behavior change programs for clients with handicaps.

| | Children | Adolescents | Adults |
|---|---|---|---|
| Social Workers | | | |
| Psychologists | | | |
| Psychology Assistants | | | |
| Psychiatrists | | | |
| Nurses | | | |



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2. How many staff members have specific training in behavior management? _____

3. Do you attempt to hire staff with expertise in behavior change programs or related skills? If so, are you able to hire staff?

_____

_____

_____

_____

4. Have your staff sought additional training in behavior management in the past 12 months? If so, how many in-services, seminars, or workshops related to behavior management have centre personnel attended?

_____Number of staff

_____Number of training sessions

_____Topics: _____

_____

_____

5. Do you have any other comments regarding concerns or needs for a community behavior management service?

_____

_____

_____

_____

_____

_____

_____

_____

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**DEFINITIONS**

**Behavior Disorder**

| | |
|---|---|
| * Socially inappropriate but not usually disruptive to other people. (e.g., self-stimulation)<br>* Generally compliant. | * Mildly disruptive to others, non-violent but annoying interpersonal behavior. (e.g., inappropriate expression of affection) |
| * Tendency to withdrawal and non-compliance, behavior interferes with training.<br>* Lack of motivation.<br>* Apparent unwillingness to change. | * Socially offensive behavior, tendency to be uncooperative and emotionally reactive if provoked.<br>* Minor offenses. (e.g., theft) |
| * Dangerous to self, othen suggestive of psychiatric disorder.<br>* Necessitates immediate intervention.<br>* Complete lack of appropriate social behavior, tends to be highly disruptive. | * Hurtful to others, destructive to property, violent emotional outbursts, verbally or physically abusive.<br>* Highly disruptive to others. |

APPENDIX E - Representatives of community agencies, provincial institutions, and school divisions contacted for the needs and resources assessment in the Northwest Region

Alberta School Systems.

1. Fairview Roman Catholic Separate School District #35
   Questionnaire Respondent: Dean Rook, Principal

2. Peace River Roman Catholic Separate School District #43
   Questionnaire Respondent: Ms. Auguette, Secretary

3. County of Grande Prairie #1
   Questionnaire Respondent: Bob Zahara, Director of Instruction

4. Thibault Roman Catholic Public School District #35
   Questionnaire Respondent: Graham Ross, Coordinator Student Services

5. Grande Prairie Roman Catholic Separate School District #28
   Questionnaire Respondent: Bill Good, Assistant Superintendent

6. Falher Consolidated Roman Catholic School District
   Questionnaire Respondent: Paul McKenna, Superintendent

7. High Prairie Roman Catholic Separate School District #56
   Questionnaire Respondent: Marvin Fyten, Superintendent

8. High Prairie School Division #48
   Questionnaire Respondent: John Ord, Assistant Superintendent

9. Grande Prairie School District #2357
   Questionnaire Respondent: Jerry Maiser, Special Education Consultant

10. County of Lac St. Anne #28
    Questionnaire Respondent: Jennifer Caswell, Learning Disability Coordinator

11. County of Barrhead #11
    Questionnaire Respondent: Janice Leonard, Deputy Superintendent

12. Spirit River School Division #47
    Questionnaire Respondent: Dick Mitton, Deputy Superintendent

13. Fort Vermilion School Division #52
    Questionnaire Respondent: Tim Bileu, Coordinator for Curriculum

14. Whitecourt School District #2376
    Questionnaire Respondent: David Thomas, Superintendent

15. Crystal Park School
    Questionnaire Respondent: Gillian Oliver, Vice-Principal

Residential Facilities

1. Smoky River & District Association for the Mentally Handicapped
   Questionnaire Respondent: Gertrude Rivard, Work Experience & Residential Coordinator

2. Grande Prairie & District Association for the Mentally Handicapped
   Questionnaire Respondent: Irene Shelp, Manager of Residential Services

3. Independent Living Service Program - Canadian Mental Health Association
   Questionnaire Respondent: Sonja Hanson, Director of Independent Living Services

4. North Central Association for the Mentally and Related Handicapped
   Questionnaire Respondent: Tudie Powlie, Supervisor/House Parent

5. Peace River & District Association for People with Special Needs
   Questionnaire Respondent: Susan McGee, Executive Director

Vocational Training Centres

1. Grande Prairie and District Association for the Mentally Handicapped
   Questionnaire Respondent: Barry Bucknell, Executive Director

2. Smoky River & District Association for the Mentally Handicapped
   Questionnaire Respondent: Gertrude Rivard, Work Experience and Residential Coordinator

3. Grande Prairie Regional College
   Questionnaire Respondent: Janet Longmate, Dolly McArthur, Human Development Department

4. Fairview College
   Questionnaire Respondent: Brenda Tosczak, Coordinator - Vocational Skills Department

5. High Prairie and District Association for the Handicapped
   Questionnaire Respondent: Vivian Torrens, Vocational Coordinator

6. Blue Heron Enterprises
   Questionnaire Respondent: Ferrel Palmer, Program Director

7. Peace River and District Association for People with Special Needs
   Questionnaire Respondent: Brenda Blair, Vocational Coordinator

Alberta Social Services & Community Health

1. Alberta Social Services and Community Health - Mental Health, Grande Prairie
   Questionnaire Respondent: Karen Walterson, Team Supervisor/ Clinic Director

2. Alberta Social Services and Community Health - Services for the Handicapped, Peace River
   Questionnaire Respondent: Janet West, Client Services Coordinator

3. Alberta Social Services and Community Health - Services for the Handicapped, Grande Prairie
   Questionnaire Respondents: Randall Kabatoff/Joanne Tanaka, Client Services Coordinator

4. Alberta Social Services and Community Health - Services for the Handicapped, High Prairie
   Questionnaire Respondent: Don Philpot, Client Services Coordinator

5. Alberta Social Services and Community Health - Consultation Services, Slave Lake
   Questionnaire Respondent: Karen Michenson, Child Development Coordinator

6. Alberta Social Services and Community Health - Behavior Management Services
   Questionnaire Respondents: John Sperry/Barbara Chaffee, Behavior Specialists

APPENDIX F - Representatives of community agencies and provincial organizations contacted for current behavior management services and related information in Alberta

1. Larry MacDonald, Director
   Darcy Marc, Residential Coordinator
   Community Behavior Services, Edmonton

2. Rnonda Clarke-Bruyn, Coordinator
   85th Street Residence, Calgary

3. Ronald G. Bell, Coordinator
   Behavior Support Team, Calgary

4. L. Brian Mitchell, Director of Treatment Services
   Mapleridge Residential Treatment Centre, Edmonton

5. Pat Martin, Residential Consultant
   Alberta Social Services and Community Health, Edmonton

6. Jane R. Silvius, Director
   Child Development Centre, Edmonton

7. Ada Bennet, Social Worker
   Michener Centre, Red Deer

APPENDIX G - Addresses for organizations currently offering behavioral services identified in Section II, Review and Analysis of Existing Systems

1. Rock Creek Foundation for Mental Health
   Bethesda, Maryland

2. The Ranch Ehrlo Society
   P.O. Box 570
   Pilot Butte, Saskatchewan
   S0G 3Z0

3. The Mapleridge Residential Treatment Centre
   8421 - 101 Avenue
   Edmonton, Alberta
   T6A 0L1

4. Forward House
   442 Spruce St.
   London, Ontario
   N5W 4P3

5. Regional Intervention Program (RIP)
   Nashville, Tennesee

6. Delta Family Services Society
   11966 - 64 Avenue
   Delta, British Columbia
   V4E 1C8

7. The Child Development Centre
   #4, 10121 - 82 Avenue
   Edmonton, Alberta
   T6E 1Z5

8. The Battlefords Mental Health Centre
   The Battlefords Union Hospital
   1080 - 107 Street
   North Battleford, Saskatchewan
   S9A 2X8

9. Behavior Management Services
   7th Floor, 214 Place
   #45, 9909 - 102 Street
   Grande Prairie, Alberta
   T8V 2V7

10. Homebound Handicapped Resource Centre
    Utah State University
    Logan, Utah 84322

11. Behavior Support Team
Department of Educational Psychology
Rm. 252 Education Block
University of Calgary
Calgary, Alberta
T2N 1N4

12. 85th Street Residence
Behavior Support Services - Calgary
P.O. Box 72
Calgary, Alberta
T2P 2H2

13. Catholic Social Services
11316 - 130 Avenue
Edmonton, Alberta
T5E 0T5

14. Westside Community Mental Health Centre, Inc.
San Francisco, California

15. Alvin Buckwold Centre
University Hospital
Saskatoon, Saskatchewan
S7Nd 0X0

16 Community Behavior Services
12813 - 116 Avenue
Edmonton, Alberta
T5M 3C8

17. Surrey Place Centre
2 Surrey Place
Toronto, Ontario
M5S 2C2

18 The Geneva Centre
204 St. George Street
Toronto, Ontario
M5R 2N5

19. The William Roper Hull Home
117 Woodpark Blvd. S.W.
Calgary, Alberta
T2W 2Z8

APPENDIX H - Needs identification survey for behavioral services; conducted by J.M. Sperry, Behavior Management Specialist, Northwest Region

NEEDS IDENTIFICATION FOR BEHAVIORAL SERVICES

Attacned is a list of questions which I would like to review with relevant agency staff concerning the needs for behavioral services. These needs will be considered in two separate questionaires, one for the present population of clients served and another for needs in light of a proposed Michener depopulation. This survey is meant to give the community agencies offering services in the Northwest Region the opportunity to have input into the possible development of a behavioral service. This survey is designed to obtain preliminary information which I will pass on in the form of a report to Social Services and Community Health. Your cooperation in reviewing these questions before we meet will be greatly appreciated.

Please call me if you have any questions (538-5148).

John M. Sperry,
Behaviour Management Specialist

Options for behavioral services to be based in the Northwest Region.

Given: proposed resources of - an outreach team and
- Residential Treatment Units (short term), one each for children and adults (3 beds each).

Purpose: To identify, informally, from a sample of community service providers, the options which would best meet the needs of handicapped persons with behavior problems.

1. Do you feel that a behavioral service should be based in the Northwest Region? Yes _____ No _____

   Why?

2. What are your present needs for behavioral management services?

   Outreach option:

   Residential option:

   (eg. staff development, consultation)

3. What on-going needs can you forecast for the next 5 years?

   Outreach option: 1 year

   3 year

   5 year

   Residential option: 1 year

   3 year

   5 year

   (eg. staff development, consultation)

4. How do you think behavioral services should be structured and used? (eg. located etc.)

   Outreach option:

   Residential option:

5. Where do you think it would be most reasonable for the behavioral service to be based?

   Outreach option:

   Residential option:

6. What kinds of support services would be reasonable for community services to offer these individuals while in treatment?

   Vocational:

   Educational:

   Leisure:

7. What are your feelings on the Behavioral Service being:

   a. based in an existing community service provider?

   Pros | Cons

   b. a government run service?

   Pros | Cons

   c. a community based service provider which only offers this service?

   Pros | Cons

8. Other Comments:

9. School Boards - what type of behavioral support will be developed by school boards for schools?

10. All Associations - if this Association were to get involved in this support service what are your concerns and needs?

    Potential problems:

    Potential Benefits:

Q. 1. All (12) of the community service providers felt that a behavioural service should be based in the Northwest Region. Most (8) stated that there is an immediate need for service which is not being met. Part of the present situation is that:

a) programs need access to behavioural services (4) whether they be school boards or community agencies.

b) there is a lack of resources available to agencies (4). For example, there are no behavioural consultation resources within any school system. One exception is Crystal Park School, Grande Prairie which has a specialist who deals specifically with multipli-handicapped children for the entire zone. For other community agencies there are two Alberta Social Services & Community Health staff who offer limited services. There are no resources in the region to house and treat aggressive individuals who have lost their residential placement. Likewise, there are no resources within this region for children who require an intensive or even a moderately intensive treatment facility.

c) there is an increasing need for behavioural services (3) because of the trend to keep children at home as well as the more sophisticated services available to younger children living in the region (eg. medical, speech therapy, physiotherapy) and Crystal Park School. The eventual effect of more children remaining at home is that there will be more adults in the community as well.

d) It is difficult to get service outside of the region (4). For example, it may take 12 months for clients to receive residential treatment in Edmonton. Part of the reason for this is that while one service has a mandate which includes the Northern Regions there are more referrals than spaces available so clients are placed on waiting lists. Having a behavioural service located in this region would make it easier to access (4) treatment.

Other points include:

e) the need for a spectrum of behavioural services (1) which would enable this region to deal more effectively with a wider range of behavioural problems.

f) at the present time, there are not enough trained staff in the region to deal with behavioural problems (1), this is true both within the community and government services.

Q. 2. All (12) community service providers expressed a need for on-going outreach consultation and identified 74 individuals who they felt required this service immediately. Most agencies (10) stated a definite need for staff development in behavioural techniques with some need (4) for staff development with those staff involved with behavioural services at the present time. Behavioural outreach was considered a preventive strategy by one major service provider which also felt that the waiting list is too long at present (eg. as of November 30, 1984 - waiting list of 14). Another major service provider identified a greater need for consultation to Early Childhood Services.

Seventeen individuals were identified as requiring short-term residential treatment immediately.

A residential treatment facility was viewed as: potentially useful for staff training (2); meeting the need to extend existing resources in the region (1); adding to the spectrum of residential resources available (1) and if available would avoid the transfer of clients out of region (18 in the last 3½ years). There is also the possibility that if such a service existed more individuals would make use of it then have been sent out of the region (1) over the last few years. One service provider felt that there was no need for a behavioural residence and that increased outreach support would meet the needs of the region.

Q. 3. All respondents identified a need for on-going consultative support but found it difficult to estimate exact numbers over a five year period. Over half (7) felt a need for residential support but were similarly unable to project any numbers (5). One agency did not like the residential facility option for service development; the preferred option was outreach services. It was estimated that approximately 40 - 50% of the special needs students attending Crystal Park School may require either outreach or residential support (1). Follow-up behavioural services were also identified as important (1).

In the area of staff development a majority expressed a need for workshops and training of directly involved staff (9) as well as for educating Boards (2). A major service provider in the Grande Prairie area expressed a need for a training program for rehab staff to be based in the Northwest, preferably at a college. Other suggestions included: an ongoing system of making referrals or evaluating student behaviour in school (1); a regional seminar for those involved with problem individuals so different management strategies can be discussed (1).

Several agencies (3) felt that there will be an increased need for service because of Michener de-population and a growing number of younger children who are already being identified as potential candidates for behavioural services.

Q. 4. The majority of those interviewed felt that outreach workers should be dispersed throughout the region (8). There were some who felt the service should be centralized (3) in one community as well as some feeling for the outreach option to be based in an existing service provider (2). Respondents felt that the service should: 1) consult to the client's network (4), 2) give workshops (1).

Responses to how the residential service should be structured include: a) residences should be located and serve a local area - if more than one residence is to be used (3): b) one residence should be considered only (2): c) a wider range of residential options need to be considered, eg. Approved homes (1): d) a residence should be considered only as long as it meets the needs (1): and e) there should be a liaison between the residence and the community (2).

Q. 5. It was suggested that outreach workers should be based in various centers such as: High Prairie and Peace River (6); Grande Prairie (5) - with the service located in the Grande Prairie Association (2), Barrhead (1); Fox Creek (1). Also suggested was basing workers in a local Association (1); have circulating workers (1); have 2 centers for staff to work from if there is a sufficient demand (1); and one suggestion was for a central administration.

Several respondents felt that if one residential unit was to be established it should be in Grande Prairie (4) and if a second unit is considered it should be located in Peace River (2) or Barrhead (1). Other suggestions were that it should be:

a) located in this region (2),
b) close to specialists for other services (1),
c) as central as possible (1).

One organization felt that the residential option would not be necessary if the outreach option existed.

Q. 6. Support Services

Vocational: The majority of respondents felt that if the client is appropriate for a vocational service then one should be made available (7). There should be liaison between services (2), as well as outreach, if necessary (1). Some (3) respondents felt that either the behaviours should be dealt with before entering a vocational center (1) or that a separate facility should be used (2) for these clients.

Educational: Most respondents felt that children should attend a community school (7). If the child does not fit into our existing service then a special program should be developed (1); outreach support should be available regardless of placement (1); moneys from local jurisdictions are necessary to operate a program in a different locality and need to be identified as soon as placement is changed (1). Individuals in a college program might be suspended until their behaviour is more appropriate (1). No comment (3).

Leisure Activities: The majority of respondents felt that if leisure activities are available in the community then clients receiving behavioural services should have access to them (8). Outreach support may be necessary (3) and in some cases a separate/specialized leisure program may be necessary if the individual is not appropriate for regular services (3). It was also mentioned that leisure activities be kept consistent with those a client is used to in order to avoid disrupting their lives any more than is absolutely necessary (1).

Q. 7a) PROS Respondents indicated the following as positive aspects associated with this option:

a) The majority of pros centered on the issue of greater community orientation and control as a desirable quality of the service and indicated specifically:

- greater community orientation (4)
- this type of service would respond better to regional needs (1).
- there would be a familiarity, on the local level, with clients, families and situations (3).
- such a service would be able to deal with a greater variety of problems or special needs of clients because services would be provided within the same organization (3).
- community monitoring pressure (1) would be an advantage.
- this type of service would save on administrative costs because it would be taken over by an already established agency (2).

b) Staff of one Association indicated that as an organization which already had experience dealing with a similar target population it could provide the service (1).

c) Others:

- one respondent felt this would be the preferred option if the service was restricted to a local level (eg. a town or city and immediate vicinity.
- Another felt that a local association could use its good relations in the community to foster a co-operative effort with other local agencies in co-ordinating services (1).
- increased accessibility (5) because the service would be located in the region.

Q. 7a) CONS Respondents felt that potential cons were:

a) those focusing on the organization itself:
   - the mandate of the organization would have to be re-evaluated because it would be local as opposed to regional in focus (2):
   - organizational changes would need to be made and this would create strain on the already existing structure (2):
   - possibly no organization could handle service delivery to the entire region (3):
   - service may not be efficient (1).

b) those focusing on the community in which the service provider exists:
   - only local people would be running it (1).
   - lack of Board expertise to run such a service (1).
   - possible negative image on other services run by the organization (1).
   - problems establishing credibility of the service (1).
   - liaison for information sharing might not be as could as it could (1).
   - team approach might be hampered if services all in one organization (1).

c) internal/government issues:
   - need for accountability and controls on the service (1).
   - government funding may not be adequate (1).

Q. 7b) PROS Respondents felt that pros related to this option included the following:

a) the government is perceived as having more financial resources which would permit:

- ability to hire well-trained staff (3).
- standards of service might be higher (2).
- funding would be better (2).
- budget control would be better (2).
- a government run service would be better able to deal with regional needs (2).
- the degree of objectivity in serving clients might be better (2).
- increased consistency (1).
- the service would have higher credibility (1).
- would provide the government with hands on experience and enable them to see the needs of service providers by operating their own service (1).
- feel comfortable with the government staff who operate the service now (1).

b) in terms of the community:

- it would not have to worry about management of the service (2).
- the community could monitor the service (1).
- it would encourage team work (1).

c) Two respondents stated that they have no concerns about a government run behavioural service.

Q. 7b) CONS Respondents felt that cons related to this option concerned issues about the government and its structure in relation to the community:

- problems with bureaucratic nature of government and government run services (6).
- the government run service would probably show too much concern over minor issues in order to "keep things safe" eg. sensitive issues (3).
- perceived interference by the government if it runs such a service (1).
- lack of availability at the local level (3).
- the service might not have the human touch or focus (1).
- there is the potential for a barrier to develop between the government and private sector - but this also happens within the private sector (1).
- the service might not be well advertised (1).
- government run services are too costly (1).
- there would be a problem regarding monitoring as the government would most likely be monitoring itself (1).

Q. 7c) PROS Respondents felt that pros for this option were:

a) related to the organization itself

- would have a specialized focus (4)
- would have a separate identity and be independent from other agencies and so more could use the service (2)
- the mandate for the organization would be clearer (1)

b) related to the community

- it would be in touch with the community (3)
- it would probably have a higher credibility in the eyes of the community (1)
- there would be a monitoring pressure from the community (1)
- positive effects as the result of having to educate the board to run such a service (1)
- a community agency could deal with regular behaviour problems but more severe ones might still have to be dealt with by a government service (1)

Q. 7c) CONS Negatives about this option include:

a) concerning the organization

- difficult for a separate service provider to establish links with other agencies on a regional level (2).
- there would be a duplication of administration costs if a separate organization (1).
- cost would be prohibitive (1).
- isolated from resources of consumers (1).
- quality of service would be questionable (1).
- still need government monitoring for standards (1).
- still need government consultant for direction (1).
- ethical issues - still have to be dealt with (1).
- potential conflict with individuals having severe behaviour problems located in a community residence (1).

b) concerning the board

- a lack of understanding of service in the community (2).
- a burden on the community for yet another board (3).
- a volunteer board can't be expected to operate such a service (2).
- unless have a strong board the whole thing would fail (1).
- some weaknesses inherent in any board (1).

c) concerning the community

- no experienced operator already existing (1).
- yet another agency to deal with (1).

d) two respondents felt there were no negative aspects to this option.

Q. 8. Comments: Respondents' general comments which were:

a) Behavioural services need to be expanded immediately (3).

b) Outreach services are most important to develop now (1).

c) an Interagency run operation would not be a good way to set up a behavioural service (2).

d) need a capacity to deal with immediate crises (1).

e) it is extremely difficult to get behavioural services at this time (1).

f) accessibility for the community is important (1).

g) standards for service need to be developed and maintained (1).

h) need good monitoring and support for behavioural services (1).

i) need to ensure good quality staff in a behavioural service (1).

j) behavioural services are not within a school board's mandate (1).

k) need an independent group dealing with behavioural services (1).

l) administration of an agency should be able to also manage a behavioural service (1).

m) the needs and abilities of individual communities need to be considered in setting up such a service (1).

n) need long term planning for the development of services (1).

0) co-ordination of services is important (1).

p) regardless of what services are put in place at the local level a government service will still be necessary to give some support (1).

q) behavioural services should also be considered for the non-handicapped population - most notably the learning disabled and those children attending Youth Assessment Centers (2).

Q. 9. School Boards

- of the four school boards sampled, 3 stated that there were no plans to develop behavioural services;
- the remaining school board already has a resource which is limited to children who are multiply handicapped and is interested in developing a behavioural resource for other children.
- one school board would not consider hiring a Behavioural Specialist but would rather focus on developing skills in teachers and aides.

Q. 10 Concerns/Problems

- there would be additional burdens placed on management and control systems (3).
- difficulty obtaining trained staff (2).
- concerns over strength of board and organization (2).
- the organization might not be sophisticated enough (2) to handle such a service.
- the Association board would have to understand behaviour management and support it (1).
- the board would have to be educated (1).
- association would not be large enough to provide a regional service (1).
- would increase expectations for more services to be developed (1).
- there would be confusion over mandate issues (1).
- an organization might have needs that would not be addressed/met locally (1).
- might not be enough clients (1).
- too costly to operate (1).

Q. 10. Benefits/positive aspects of operating such a service (for an organization) included:

- if the Association has credibility so will the new service (1).
- Associations should be involved in such a service (1).
- present staff are enthusiastic about the service (1).
- a certain amount of consistency would be provided to clients as they would be maintained mostly within the Association's system (1).
- there would be greater flexibility to re-integrate back into the community (1).
- the group would already have experience and awareness of dealing with the mentally handicapped (1).
- the service would be located in this region (1).
- would be working from an established community base (1).
- would know clients and family (1).
- Grande Prairie is the largest center and would be best suited to such a service (1).

MICHENER DEPOPULATION

Given: Clients may be moved from Michener Centre to the Northwest Region in the near future.

Purpose: To identify the behavioral resources needed to meet community agency needs.

1. Have you have experience with de-institutionalized clients? Yes _____
   No _____

2. Would special support be required for de-institutionalized clients? Yes _____
   No _____

3. What type of support(s) would be necessary?

4. What type of Behavioral Support would be needed?

   Outreach -

   Training -

   Counselling -

   Resident Facility -

5. For how long would support be necessary?
   eg.. prep time with staff for 2-months
   - on-going support for several months

## MICHENER DE-POPULATION

This survey is based on 8 Association contacts:

1. & 2. Respondents generally had some experience in working with de-institutionalized clients (6), only 2 did not. All felt that specialized supports would be necessary for the de-institutional client.

3. The types of supports necessary as indicated by respondents were:

a) program related:

Behavioural - in the community (6)
- prior to leaving institution (1)
- residential treatment unit available if needed in the community (1)

Counselling - in the community (2)

Vocational & Rehabilitation program - (3)

Life skills (includes I.L.S., community orientation social skills training) - (4)

Specific therapies (physio, vision) - (2)

b) Community and Organizational support (3)
- in-services for boards
- to increase sophistication of agency
- educate community

c) supports specific to client - individualized (2)
- 1 : 1 aide (1)
- support system for client (1)
- financial aid (1)
- advocacy (1)

4. Behavioural Support Needs

a) Outreach

- a worker available to immediately work with client when he/she returns to region (3).
- consultation to existing service providers (3).
- to facilitate family interaction and counselling (2).
- if the individual needs service it should be provided (2).
- staff development (1).
- the outreach worker should have a lighter caseload if only dealing with Michener clients.

b) Behavioural Support in Vocational Settings

- workshops and training in behaviour management (6).
- social and life skills training (4).
- in all areas of vocational work (3).
- community integration skills (2).
- depends on client need (1).
- general training for the client (1).

c) Counselling services

- should come from mental health(2); should deal with personal counselling (1), inter personal relations (2) and how to adjust to new expectations of community life (2).
- one worker should be in charge of such counselling (1).
- adapt the program to the person (1).
- <u>if</u> have lots of trained staff counselling should occur (1).

d) Community Residence: Respondents were generally in favor of some type of support:

- it probably will be needed (4).
- there should be beds available if there is a need (2).
- some beds should be available for relief but not treatment (1).
- other resources in the continuum of residential resources need to be developed instead (1).

One respondent felt this was not a desirable option.

5. Duration of support: Some type of support was indicated by all respondents. The options include:

- base it on the needs of the client (5).
- on-going support (5).
- prior staff training (5).
- immediately after discharge (1).
- long term support (1).

| | | Barrhead | Grande Prairie | High Level | High Prairie | Peace River | Slave Lake | Whitecourt/Fox Creek | | Michener Center Target Population | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| No age | | | | | | | | | 0 | | |
| Pre-schoolers | 0 - 4 yrs. | 0 | 4 | 0 | 0 | 3 | | 0 | 7 | 0 | |
| Elementary | 5 - 9 yrs. | 6 | 15 | 2 | 5 | 6 | | 2 | 34 | 0 | |
| Adolescents - Teens | 10 - 17 yrs. | 15 | 10 | 1 | 16 | 23 | | 0 | 65 | 0 | |
| Adults | 18 - 55 yrs. | 15 | 27 | 21 | 8 | 18 | | 0 | 89 | 7 | |
| Seniors | 56 + yrs. | 1 | 0 | 0 | 0 | 0 | | 0 | 3 | 3 | |
| | | 37 | 56 | 26 | 29 | 50 | | 2 | 198 | 10 | 220 |
| | | | | | | in-compl. info (18-55) | | | 12 | | |
| | | | | | | | | | 210 | | |

NW Region
Jan 22/85

BCHAD - DEFINITIONS

| | Level → I | II | III | IV | |
|---|---|---|---|---|---|
| 0 - 4 | 2 | 3 | 2 | - | 7 |
| 5 - 9 | 6 | 9 | 15 | 4 | 34 |
| 10 - 17 | 17 | 26 | 21 | 1 | 65 |
| 18 - 55 | 18 | 36 | 27 | 8 | 89 |
| 55 + | 2 | - | 1 | - | 3 |
| | 45 | 76 | 66 | 13 | 198 |
| Michener | 4 | 6 | - | - | 10 |
| | 49 | 82 | 66 | 13 | 208 |
| | | | | incomplete | 12 |
| | | | | | 220 |



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## BEHAVIOR DEFINITIONS

The following definitions are being used for the purposes of this survey:

1. Mentally Handicapped Person - any person who has a significant intellectual impairment, whether socio-economic or organic in origin, which exist concurrently with deficits in adaptive behavior and is manifested during the developmental period (i.e. before 18 years).

2. Mild Behavior Problem - socially inappropriate and mildly disruptive behavior, eg. inappropriate expression of affection; non-violent but annoying interpersonal behavior.

3. Moderate Behavior Problem - ranges from nuisance or compulsive behaviors, and non-compliance, to minor property offences, and delinquencies, eg. aggression against work environment; shoplifting; exhibitionism.

4. Severe Behavior Problem - danger to self or others, and/or destruction of property, often with severe medical or psychiatric problems and a lack of communication or interpersonal skills, eg. attacking others; extreme self-abuse.